

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the funeral director prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12731 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 12707 31
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND					<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville 8.</b>					c. LENGTH OF STAY IN 1b <b>4-72</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7628 Carla Rd</b>					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville 8.</b>					
f. STREET ADDRESS <b>7628 Carla Rd</b>					g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>SYDNEY BERNARD ALBERT</b>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 1, 1914</b>	9. AGE (in years last birthday) <b>83 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Jewelry</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Sidney Albert</b>					14. MOTHER'S MAIDEN NAME <b>Ida Rock</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>216-05-0817</b>		17. INFORMANT <b>Henry Goldsmith - 3404 Baltimore Rd.</b>		Address <b>3404 Baltimore Rd.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i></b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b>										
DUE TO <b>(c)</b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>								
20c. TIME OF INJURY Hour a. m. p. m. <b>None 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) <b>None</b>		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								DATE SIGNED <b>12-6-57</b>
EXAMINER'S NAME (Type) <b>D. D. CAPLES</b>										
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-8-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Herring Run</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc 2100 Eutaw Place</b>		ADDRESS <b>2100 Eutaw Place</b>		24a. REC'D. BY REGISTRAR <b>DEC 10 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Kelly</b>				
VS. A15ME(5) 5M 9/55										

BUREAU V. S

DEC 10 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

127083

12732

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Roseburg</b>		c. LENGTH OF STAY IN lb <b>6</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 304 Gumspring Rd.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Roseburg</b>	
3. NAME OF DECEASED (Type or print) <b>Steven</b>		First <b>Carol</b>	Middle <b>Amos</b>
4. DATE OF DEATH <b>Dec 12 1957</b>		Month <b>Dec</b>	Day <b>12</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>6-12-57</b>		9. AGE (in years last birthday) yrs. <b>5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alfred Amos</b>		14. MOTHER'S MAIDEN NAME <b>Ella May Dorsey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>499X</b>		16. SOCIAL SECURITY NO. <b>Pneumonia</b>	
17. INFORMANT <b>Father</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b)</b> DUE TO <b>(c)</b>	
		INTERVAL BETWEEN ONSET AND DEATH <b>undet</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>John C. Hyde</b>		DATE SIGNED <b>12-12-57</b>	
EXAMINER'S NAME (Type) <b>John C. Hyde</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-14-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>MT. CALVARY</b>
22d. LOCATION (City, town, or county) <b>A. A. County, Md</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph S. Locke, Jr.</b>		ADDRESS <b>1304 N. Central Ave</b>	24a. REC'D BY REGISTRAR DATE <b>12/12/57</b>
		24b. REGISTRAR'S SIGNATURE <b>Mrs. J. L. Lieberman</b>	
		1000330XVS	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-troumal permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

BUREAU V. S.

DEC 13 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12733 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12709

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 637 Coleraine Rd.		d. STREET ADDRESS 637 Coleraine Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM		First	Middle	Last	4. DATE OF DEATH Month December Year 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 10, 1919	9. AGE (In years last birthday) 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto Body Shop		11. BIRTHPLACE (State or foreign country) McKeesport, Penna.	
13. FATHER'S NAME — Andres		14. MOTHER'S MAIDEN NAME — Fulmer		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no., or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Catherine L. Andrews, 637 Coleraine Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis.		Address			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Paul F. Guerin</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		DATE SIGNED 12/26/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 30.57		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cem.	
22d. LOCATION (City, town, or county) (State)		22e. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE THOMAS J. KENNY, INC. 1600		ADDRESS HOLLINS ST. BALTIMORE, MD.		24a. REC'D BY REGISTRAR DAEDEC 27 '57	
				24b. REGISTRAR'S SIGNATURE <i>John J. Guerin</i>	

BUREAU V.

DEC 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 1SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12710

12734

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>51 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>512 Cording Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>BERNARD</b>	Middle ---	Last <b>APPEL</b>	4. DATE OF DEATH <b>December</b>	Month <b>18</b>	Day <b>18</b>	Year <b>19 57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 10, 1897</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Roofing Business</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Bernard Appel</b>				14. MOTHER'S MAIDEN NAME <b>Ida Berndt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <b>WW I 216-10-1351</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>522X</b> DUE TO <b>UNKNOWN CAUSE</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>1. Gangrene, right foot. 2. Multiple sclerosis.          Operation - Hemorrhoidectomy, 10 years ago.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day VA	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that attended the deceased from <b>October 28, 1957</b> to <b>December 18, 1957</b> , and that death occurred at <b>8:35A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Joseph M. Miller</i>	ADDRESS (Street, city or town, state) <b>M.D. VAH, FORT HOWARD, MARYLAND</b>						DATE SIGNED <b>12/18/57</b>
PHYSICIAN'S NAME (Type) <b>JOSEPH M. MILLER, M.D., Chief, Surgical Service</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec 21, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Govans Presbyterian Cem.</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran, 3000 E. Baltimore St., Baltimore, Md.</b>		ADDRESS <b>Reverend Stirling</b>	DH	24c. REC'D BY REGISTRAR <b>1957</b>	24b. REGISTRAR'S SIGNATURE <b>D. L. Farber</b>		

CERTIFICATE OF DEATH

BUREAU Y. S.

DEC 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12735 CERTIFICATE OF DEATH

12711

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	c. LENGTH OF STAY IN 1b <i>3 months</i>	b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>CATON RIDGE NURSING HOME</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i>	
3. NAME OF DECEASED (Type or print) <i>MARY</i>		First <i>ARMAN</i>	Middle Last
4. DATE OF DEATH <i>DEC.</i>	Month <i>16<sup>th</sup></i>	Day <i>MON.</i>	Year <i>1957</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/9/1882</i>
9. AGE (In years lost birthday) <i>75 yrs.</i>	10. IF UNDER 1 YEAR Months <i>75</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>JACOB</i>	14. MOTHER'S MAIDEN NAME <i>FRANCES CHMIELEWSKI</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>447-14-9111</i>	17. INFORMANT <i>DOROTHY EIN WILIT 49-ILPMANVIR</i>	Address <i>1120 E. 36TH ST. BALTIMORE MD 21212</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
447X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Arteriosclerosis &amp; Hypertension</i>		DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Hypertension</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Malaria</i>			
20a. MEDICAL CERTIFICATION <input type="checkbox"/>	20b. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Dec. 13 1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4605 Edmondson Ave.</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12/10/57</i> , 1957, to <i>12/16/57</i> , 1957, that I last saw the deceased alive on <i>12/13/57</i> , and that death occurred at <i>2:22 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Cliff Ratliff, Jr.</i>			
PHYSICIAN'S NAME (Type) <i>CLIFF RATLIFF, JR.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>12/18/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>HOLY REDEMPTION</i>	22d. LOCATION (City, town, or county) (State) <i>BALTIMORE MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Cliff Ratliff, Jr.</i>	ADDRESS <i>4605 Edmondson Ave.</i>	24a. REC'D BY REGISTRAR DATE <i>DEC 19 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Debby</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF DEFENSE - STATE OF TEXAS - SAN ANTONIO

CERTIFICATE OF TRANSMISSION

RECEIVED

BUREAU V.

DEC 19 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12736 CERTIFICATE OF DEATH**

Reg. Dist. No. **12718**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fssex</b>		c. LENGTH OF STAY IN 1b <b>16</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7224 Eastern Ave.</b>			d. STREET ADDRESS <b>7224 Eastern Blvd</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>E</b>	Last <b>ATKINSON</b>	4. DATE OF DEATH Month <b>DEC</b>	Day <b>4</b>	Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 4, 1872</b>	9. AGE (In years lost birthday) <b>85</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>track foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Cecil Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elisha A. Atkinson</b>			14. MOTHER'S MAIDEN NAME <b>Isabel Jay</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>705-09-7438</b>		17. INFORMANT <b>Raymond S. Atkinson</b> Address <b>7224 Eastern Blvd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Vascular Accident (2nd)</b> DUE TO (c) <b>Advanced, generalized Atherosclerosis &amp; HCVD</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Malnutrition and electrolyte imbalance Secondary to (a) above</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>19</b>	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baltimore</b>	(County) <b>Maryland</b>	(State)
21. I certify that I attended the deceased from <b>Mar. 1956</b> to <b>Dec. 1 1957</b> , that I last saw the deceased alive on <b>Dec. 3 1957</b> , and that death occurred at <b>9:15 p.m.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>M.D. 7527 Belair Rd. Balto. 6 Md.</b> DATE SIGNED <b>Dec 6, 57</b>							
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) <b>JOHN C. HYDE MD</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>Dec. 8, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Zion Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lorothy Funeral Home</b>				ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D. BY REGISTRAR <b>DEC 9 1957</b>	24b. REGISTRAR'S SIGNATURE 

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A.C. 1912

250

James

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12737 CERTIFICATE OF DEATH

12713  
Reg. Dist. No. 182

1. PLACE OF DEATH <b>ROSEWOOD STATE TRAINING SCHOOL</b> a. COUNTY <b>BALTIMORE</b>		USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>		c. LENGTH OF STAY IN lb <b>16 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 16, Maryland</b>	
3. NAME OF DECEASED (Type or print) <b>John Lynn</b>		d. STREET ADDRESS <b>2104 E/Sinor AVENUE</b>	
4. SEX <b>Male</b>		First <b>John</b>	Middle <b>Lynn</b>
5. COLOR OR RACE <b>White</b>		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	7. DATE OF BIRTH <b>2/29/35</b>
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) <b>22 yrs.</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gilbert Bannister</b>		14. MOTHER'S MAIDEN NAME <b>Lucile Schuler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Rosewood Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH</span>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia (Acute Bronchitis)</b> DUE TO <b>1/1X</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Decubitus ulcer of the sacrum</b> DUE TO (c) <b>Spastic Quadriplegia</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Microcephaly</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/18</b> , 19 <b>57</b> , to <b>12/18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12/18</b> , 19 <b>57</b> , and that death occurred at <b>1/45A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ernest J. DeLoach</b>		ADDRESS (Street, city or town, state) <b>Rosewood Lane Owings Mills, Md.</b> DATE SIGNED <b>12/18/57</b>	
PHYSICIAN'S NAME (Type) <b>ERNEST J. DECUS</b>			
22c. BURIAL CREMATION REMOVAL (Specify)		22d. DATE THEREOF	
<b>Burial Dec. 24/1957</b>		22e. NAME OF CEMETERY OR CREMATORIUM <b>Wadlington M. &amp; Sons</b>	
22f. LOCATION (City, town, or county) <b>Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>V. D. Bailey</b>		24a. REG'D BY REGISTRAR DATE <b>Dec. 24, 1957</b>	
ADDRESS <b>Wadlington M. &amp; Sons</b>		24b. REGISTRAR'S SIGNATURE <b>C. A. Kindred</b>	
		Mary E. Lopez	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGIVEL Y. S.

DEC - 1977

REGIVEL

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**12738 CERTIFICATE OF DEATH**

Reg. Dist. No. **12714**

3								
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oaklee Village</b>		c. LENGTH OF STAY IN 1b <b>128 Oaklee Village</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>128 Oaklee Village</b>		e. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Md.</b>						
f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oaklee Village</b>		b. COUNTY <b>128 Oaklee Village</b>						
g. STREET ADDRESS <b>128 Oaklee Village</b>		h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Margaret Barber</b>		First <b>Margaret</b>	Middle <b>Barber</b>					
4. DATE OF DEATH <b>Dec. 15/57</b>	Month <b>Dec.</b>	Day <b>15</b>	Year <b>1957</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, 1897</b>					
9. AGE (In years last birthday) <b>60 yrs.</b>	10. IF UNDER 1 YEAR <b>Months</b>	11. IF UNDER 24 HRS <b>Days</b>	12. IF UNDER 24 HRS <b>Hours</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	11. BIRTHPLACE (State or foreign country) <b>Germany</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Harrer</b>	14. MOTHER'S MAIDEN NAME <b>Unknown</b>	Address <b>Mrs. Helen Cullen, 128 Oaklee Village</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO <b>218 12 4950</b>	17. INFORMANT <b>Mrs. Helen Cullen, 128 Oaklee Village</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>(b)</b> DUE TO <b>(c)</b>	INTERVAL BETWEEN ONSET AND DEATH <b>9 mos</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>THROMBOPHLEBITIS LEFT LEG</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> p. m.	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>M.D. 3101 W BALTIMORE ST.</b>	20f. (City or town) <b>Baltimore</b>	(County) <b>Maryland</b>	(State) <b>MD</b>
21. I certify that I attended the deceased from <b>OCT 10, 1957</b> , to <b>DEC 15, 1957</b> , that I last saw the deceased alive on <b>DEC 17, 1957</b> , and that death occurred at <b>5:45A M</b> , from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <b>MARYLAND</b>		ACTUAL SIGNATURE <b>KENNARD YAFFE</b>	DATE SIGNED <b>12/17/57</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/17/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park</b>	22d. LOCATION (City, town, or county) <b>Baltimore</b>	(State) <b>MD</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nitzke Funeral Directors, 4101 Edmondson</b>	ADDRESS <b>12/17/57</b>	24a. REC'D BY REGISTRAR • REC'D BY REGISTRAR'S SIGNATURE <b>12/17/57</b>	REGISTRAR'S SIGNATURE <b>12/17/57</b>	DATE <b>12/17/57</b>				

3. A. 1952

1952

27



FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the Board of Health, or if designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										REG. DIST. NO. 12715	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
ITEMS 1, 2, 8&9 Film GEL 3 12/27/71											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>174 Cinder Road</b>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>MARIAN ELLEN BEARDSLEY</b>		First	Middle	Lost	4. DATE OF DEATH <b>December 9, 1957</b>	Month	Day	Year			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH <b>22 October 27, 1957</b>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years least birthday) yrs <b>19</b>	10. UNDER 1 YEAR Months <b>19</b>	11. UNDER 24 HRS Days <b>19</b>	Hours <b>19</b>	Min <b>19</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baby</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Warren M. Beardsley</b>		14. MOTHER'S MAIDEN NAME <b>Kathryn Walsh</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Warren H. Beardsley, Timonium, Maryland</b>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), <u>storing the underlying</u> <u>cause lost</u> . DUE TO (c)		Upper Respiratory Infection 24 Hours INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		DATE SIGNED <i>12/9/57</i>									
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 12, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>May's Chapel Cemetery</b>		22d. LOCATION (City, town, or county) <b>Timonium, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Burns Sonos</i>		ADDRESS <b>Towson, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 13 '57</b>		24b. REGISTRAR'S SIGNATURE <i>Altheuer</i>					

BUREAU V. A.

EE

REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12740

## CERTIFICATE OF DEATH

12716/5  
Reg. Dist. No.

1. PLACE OF DEATH o COUNTY  Baltimore County		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE b. COUNTY  Maryland	
b. CITY OR TOWN IN WHICH Corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Middle River		c. LENGTH OF STAY IN lb 4 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Tvy Hall, 190 Harrison Ave.		d. STREET ADDRESS Baltimore 1740 Fleet St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna		First	Middle
4. DATE OF DEATH Dec 31 1957		Last	Month Day Year
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May. 9. 1873		9. AGE (in years last birthday) 84 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Ferdinand Schneider		14. MOTHER'S MAIDEN NAME Anna Woelfel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Ferdinand E. Behr. 2600 Jefferson St. Balto.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 1957 to Dec 21, 1957, that I last saw the deceased alive on Dec 31, 1957, and that death occurred at 6 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Y.M. Barnardine, M.D. Baltimore Md. DATE SIGNED PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 3. 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery		22d. LOCATION (City, town, or county) Baltimore Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS. INC. Baltimore Md.		24a. REC'D BY REGISTRAR DATE Jan 3 1958	
		24b. REGISTRAR'S SIGNATURE Edith Turley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

19.8

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1274 CERTIFICATE OF DEATH

12717 40

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN	Baltimore MARYLAND Kingsville	STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kingsville	(If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Bradshaw Rd.	STREET ADDRESS	Bradshaw Rd.
<b>3. NAME OF</b> (First) <i>Bertha</i> (Middle) <i>S.</i> (Last) <i>Bell</i> (Type or Print)			<b>4. DATE OF DEATH</b> Dec. 5 1957
<b>5. SEX</b> <i>F</i>	<b>6. COLOR OR RACE</b> <i>W</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Married</i>	<b>8. DATE OF BIRTH</b> April 22, 1878
<b>10e. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>At Home</i>	<b>11. BIRTHPLACE</b> (State or foreign country) <i>Balto. Co. Md.</i>
<b>13. FATHER'S NAME</b> <i>Jarrett Standiford</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Annie E. Wood</i>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i>		<b>16. SOCIAL SECURITY NO.</b> <i>None</i>	<b>17. INFORMANT &amp; ADDRESS</b> <i>Mr. William W. Bell Kingsville, Md.</i>
<b>18. MEDICAL CERTIFICATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Congestive heart failure</i>			
ANTECEDENT CAUSE(S) DUE TO <i>Pneumonia</i>			
DISEASES OR CONDITIONS, IF ANY, ■ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Arteriosclerotic cardiovascular Disease</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>CVA left side paraparesis</i>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from Dec. 5, 1957, to Dec. 5, 1957, that I last saw the deceased alive on Dec. 5, 1957, and that death occurred at 6:30 P.M. from the causes and on the date stated above.</b>			
SIGNATURE <i>William W. Johnson</i> M.D. ADDRESS (Street, city, town, state) <i>1125 1/2 St. N.E. Washington, D.C.</i> DATE SIGNED <i>12-5-57</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>Dec. 8, 1957</i>	<b>NAME OF CEMETERY OR CREMATORIUM</b> <i>Salem Methodist</i>
<b>24. REC'D BY REGISTRAR</b> <i>DEC 9 1957</i>		<b>REGISTRAR'S SIGNATURE</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Dr. Walter Johnson, Franklinville Funeral Home</i>
DATE <i>DEC 9 1957</i>		ADDRESS <i>Franklinville Rd. Balt. Co.</i>	

**INSTRUCTIONS**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12788

## 12742 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 613 St. Francis Road		e. STREET ADDRESS 1613 St. Francis Road	
3. NAME OF DECEASED (Type or print) First Middle Last Mr. Edward Joseph Bennett		4. DATE OF DEATH Month Day Year December 25th 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Bennett		14. MOTHER'S MAIDEN NAME Mary Anna Schmidt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Laura Rita Bennett, 613 St. Francis	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 16		20f. (City or town) Baltimore (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE JOSEPH J. CAMERON		ADDRESS (Street, city or town, state) 1515 Martin Blvd 12/26/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/57	
22c. NAME OF CEMETERY OR CREMATORIUM Moreland Mem. Park		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE 12/26/57	
		24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 2 should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 4 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 12715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 Reg. Dist. No. 41  
 12715

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by the funeral director.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>M D</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. LENGTH OF STAY IN 1b <b>2 yrs.</b>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK (22)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NELLIE HEIM BENNETT</b>		First <b>NELLIE</b>	Middle <b>HEIM</b>
4. DATE OF DEATH <b>12-24-1957</b>	Month <b>Dec</b>	Day <b>24</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 5, 1895</b>
9. AGE (In years last birthday) <b>62 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	11. KIND OF BUSINESS OR INDUSTRY <b>—</b>	12. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>
13. FATHER'S NAME <b>W.M. BENNETT</b>	14. MOTHER'S MAIDEN NAME <b>ANNA BRAUM</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>192-18-2187</b>		17. INFORMANT <b>MRS. MARION STANLEY - DUNDALK, MD</b>	Address <b>—</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4020.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). <b>—</b>		DUE TO <b>(b) A-S-C-V Disease</b>	
DUE TO <b>(c) —</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>
20f. (City or town) <b>—</b>	(County) <b>—</b>	(State) <b>—</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M. B. Davis</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>M. B. Davis MD</b>	12/27/57		
22a. BURIAL, CREMATION, REMOVAL (Select) <b>Burial</b>	22b. DATE THEREOF <b>12/27/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>FAIRVIEW CEM.</b>	22d. LOCATION (City, town, or county) <b>BALTIMORE, MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Lumpkin Bradley, Dundalk, MD</b>	ADDRESS <b>—</b>	24a. MORTUARY REGISTRAR DATE <b>DEC 21, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Dr. Gust M. Kieffer</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12743 CERTIFICATE OF DEATH

12720

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Hagerstown</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN lb <b>5 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>RFD # 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Harrison</b>	Middle	Last <b>Bishop</b>	4. DATE OF DEATH <b>Sept 5, 1957</b>	Month <b>12</b>	Day <b>25</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-22-02</b>	9. AGE (In years last birthday) <b>55 yrs.</b>	10. IF UNDER 1 YEAR Months <b>11</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James L. Bishop</b>		14. MOTHER'S MAIDEN NAME <b>Maggie R. Bishop</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>262-7-</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Histoplasmosis</b>							
DUE TO <b>134.d</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20e. TIME OF INJURY Hour a. m. p. m. 19		20f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-22-57</b> , to <b>12-25-57</b> , that I last saw the deceased alive on <b>12-22-57</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED <b>William Newcomer</b>							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D., Superintendent</b>							
22e. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial Dec 29, 1958 Belair Memorial Park, Takoma Park, Maryland</b>		22f. DATE THEREOF <b>Dec 29, 1958</b>		22g. NAME OF CEMETERY OR CREMATORIAL <b>Belair Memorial Park, Takoma Park, Maryland</b>		22h. LOCATION (City, town, or county) (State) <b>Takoma Park, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mr. Bailey Washington, M.D.</b>		ADDRESS <b>1101 3rd Street, Baltimore, Maryland</b>		24. REG'D BY REGISTRAR <b>Dec 29, 1958, C. G. Clark</b>		24h. REGISTRAR'S SIGNATURE <b>Dorothy Harrell</b>	
VS A15 (4) 1SM 9/55							

BRUNSWICK

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12744 CERTIFICATE OF DEATH

12721

44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fallston</b>		d. STREET ADDRESS <b>None</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>EARIE</b>		First <b>W.</b>	Middle <b>BLACKBURN</b>	4. DATE OF DEATH <b>December 14</b>	Month <b>1957</b>	Day	Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/12/91</b>	9. AGE (In years lost birthday) <b>63 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Robert Henry Blackburn</b>		14. MOTHER'S MAIDEN NAME <b>Cecilia Spicer</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-03-5873</b>		17. INFORMANT <b>Clin. Recs. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY ABSCESS</b> <b>521X</b> DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AN AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from November 27, 1957, to December 14, 1957, and that death occurred at 5:40 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <b>Leonard D. Mark</b>				ADDRESS (Street, city or town, state)		DATE SIGNED <b>12/14/57</b>		
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/17/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Hiss Methodist Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore County, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Harford Rd.</b>		24e. REC'D BY REGISTRAR <b>DATE 12/17/57</b>		24b. REGISTRAR'S SIGNATURE <b>Leonard J. Ruck</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4  
 it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12722

## 12745 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 50 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		d. STREET ADDRESS Berrymans Lane	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100 Berrymans Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Nora	Middle Agnes	Last Bollinger	4. DATE OF DEATH	Month Dec. 5, 1957	Day 19
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH May 24, 1907	9. AGE (in years last birthday) 50 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Govt. Employee			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Sylvester Bollinger				14. MOTHER'S MAIDEN NAME Margaret Flynn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO		17. INFORMANT Michael J. Bollinger, Baltimore, Md.		
Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  b. DUE TO  c. DUE TO  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  INTERVAL BETWEEN ONSET AND DEATH 40 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1950, to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at _____, 7 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Alice D. Eline</i> M.D. 413 Reisterstown Rd., Dec 6, 1957 PHYSICIAN'S NAME (Type) Physician's Name <i>Alice D. Eline</i> M.D. 413 Reisterstown Rd., Dec 6, 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 9, 1957		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE 12-6-57		24b. REGISTRAR'S SIGNATURE Mary B. Eline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12723

44

## 12746 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>43 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>2745 N. Calvert St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>TRA</b>	Middle <b>W.</b>	Last <b>BOZMAN</b>	4. DATE OF DEATH <b>December 20 1957</b>	Month <b>December</b>	Day <b>20</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1895</b>	9. AGE (In years (last birthday) <b>62 yrs.</b>	10. IF UNDER 1 YEAR Months <b>62 yrs.</b>	11. IF UNDER 24 HRS. Days <b>62 yrs.</b>	12. IF UNDER 24 HRS. Hours <b>62 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman - Accentnt</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rug Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Cape Charles, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Bozman</b>		14. MOTHER'S MAIDEN NAME <b>Sara Wallace</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WW I 215-07-7256</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOMEGLALY WITH HYPERTROPHY AND DILATATION</b> of <b>UNKNOWN</b> RIGHT AND LEFT VENTRICLES Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Due to: HYPERTENSIVE AND ARTERIOSCLEROTIC CARDIO-</b> VASCULAR DISEASE <b>14 YEARS</b> (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VA</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 7, 1957</b> , to <b>December 20 1957</b> , and that death occurred at <b>7:50A M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA FT. HOWARD, MARYLAND</b> DATE SIGNED <b>12/20/57</b>							
ACTUAL SIGNATURE <b>Chien Wei Lan</b> NAME (Type) <b>CHIEN WEI LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-23-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tickner North &amp; Pa. Ave Balto. Md</b>							
24a. REC'D BY REGISTRAR <b>DEC 21 1957</b>				24b. REGISTRAR'S SIGNATURE <b>Lawson L Farley</b>			

BUREAU V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12747 CERTIFICATE OF DEATH

12724

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>22 days</b>		a. STATE <b>Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		b. COUNTY	
3. NAME OF DECEASED (Type or print) <b>DONALD</b>		First <b>F.</b>	Middle <b>F.</b>	Last <b>BROWN</b>	4. DATE OF DEATH <b>December 28 1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3/21/33</b>	9. AGE (In years lost birthday) <b>24 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oiler-Checker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Nolan S. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Anna Jones</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>PL-28 216-30-5855</b>		17. INFORMANT <b>Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>NEOPLASM, METASTATIC</b>  178X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) <b>EMBRYONAL CARCINOMA LEFT TESTICLE</b>		<b>16 MONTHS</b>			
DUE TO  (b) DUE TO  (c)		<b>18 MONTHS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m. 19		Month Day Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>December 6, 1957</b> , to <b>December 28, 1957</b> , and death occurred at <b>12:40 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>W. C. DUDLEY, M.D.</b> M.D. <b>VAH Fort Howard, Md.</b> 12/28/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-31-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Meadowridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook-Bright, Inc. 6009 Harford Rd</b>		ADDRESS <b>6009 Harford Rd</b>		24a. REC'D BY REGISTRAR DATE <b>12/30/57</b>	24b. REGISTRAR'S SIGNATURE <b>Benson L. Fisher</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12748 CERTIFICATE OF DEATH

1272533

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hickmanstown</i>	c. LENGTH OF STAY IN 1b <i>10 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hickmanstown</i>	d. COUNTY <i>Baltimore</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Chromine Road</i>		d. STREET ADDRESS <i>Chromine Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>HESTER</i>	First <i>V.</i>	Middle <i>Brown</i>	Last <i>December 25 1957</i>
4. DATE OF DEATH Month <i>December</i>	Year <i>1957</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 28, 1879</i>
9. AGE (In years last birthday) <i>78 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housework</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Lewis Brown</i>	14. MOTHER'S MAIDEN NAME <i>Mary Meyers</i>	Address <i>Kosie A. Nelson, Chromine Rd, Hickmanstown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>[Illegible]</i>	17. INFORMANT <i>Kosie A. Nelson, Chromine Rd, Hickmanstown</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> (c) <i>Hypertension</i>
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> <i>Years</i> <i>Years</i>
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>February 1956</i> to <i>December 25 1957</i> , that I last saw the deceased alive on <i>December 24 1957</i> , and that death occurred on <i>Dec 25 1957</i> at <i>3:30 P.M.</i> from the causes and on the date stated above ACTUAL SIGNATURE <i>Clarence E. McWilliams</i> M.D. ADDRESS (Street, city or town, state) <i>Hickmanstown, Maryland Dec 25, 1957</i> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>12-28-1957</i>	22c. NAME OF CEMETERY <input type="checkbox"/> CEMETERY <i>Druid Ridge</i>	22d. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. M. Waltz,</i>		ADDRESS <i>Winfield, Md.</i>	24a. REC'D BY REGISTRAR <i>DATE DEC 30 1957</i>
			24b. REGISTRAR'S SIGNATURE <i>Mary Elmer</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Permit. Then please move carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12749 CERTIFICATE OF DEATH

12726

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1 PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b <b>18 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First <b>RAYMOND</b>	Middle <b>BROWNING</b>	Last Month Day Year 12 24 1957
4. DATE OF DEATH			
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-10-04</b>
9 AGE (in years last birthday) <b>53 yrs</b>		10. KIND OF BUSINESS OR INDUSTRY <b>CHAMBERLAIN, CITY OF BALTO.</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>GEORGE BROWNING</b>	
14. MOTHER'S MAIDEN NAME <b>ELIZABETH MANGRUM</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO (If yes, give war or date of service) <b>213-03-8884</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <b>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS</b> <b>502X</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.</b> <b>(b)</b> <b>DUE TO</b> <b>(c)</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7-6-1955</b> , to <b>12-24-1955</b> , that I last saw the deceased alive on <b>12-24-1955</b> , and that death occurred at <b>5:45 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>William Newcomer, M.D.</b> <b>Mt. Wilson, Maryland</b> <b>12-24-55</b>			
ACTUAL SIGNATURE <b>William Newcomer</b>		PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b> Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-27-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>A. A. Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WITZKE FUNERAL DIR. EDMONDSON</b>		ADDRESS <b>4101 AVE</b>	24a. REC'D BY REGISTRAR DATE <b>12/27/57</b>
			24b. REGISTRAR'S SIGNATURE <b>Dorothy Jewell</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 12750 CERTIFICATE OF DEATH

12727

38

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>BALTIMORE</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>M.D.</i>		b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TOWSON</i>		c. LENGTH OF STAY IN lb <i>LIFE</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TOWSON</i>		d. STREET ADDRESS <i>435 E. PENNA. AVE</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>435 E. PENNA. AVE</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>HARRIETT E. BUCHANAN</i>		First	Middle	Lost	4. DATE OF DEATH 13	Month	Day	Year 1957
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1904</i>	9. AGE (In years last birthday) <i>53</i>	10. IF UNDER 1 YEAR Months <i>5</i>	11. IF UNDER 24 HRS Days <i>5</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DOMESTIC</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>PRIVATE FAMILY</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>ALBERT WILSON</i>		14. MOTHER'S MADDEN NAME <i>MARY JANE</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO <i>214-14-0877</i>		17. INFORMANT <i>REGINA WILSON</i>		Address <i>437 E. PENNA. AVE</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>cerebro vascular hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH <i>8 WKS 4 DAYS</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		<i>Generalized arteriosclerosis + hypertension</i>						
DUE TO (c)								
DUE TO (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>TOWSON</i>		(County) (State) <i>M.D.</i>
21. I certify that I attended the deceased from <i>NOV. 15</i> , 19 <i>57</i> to <i>DEC. 5</i> , 19 <i>57</i> that I last saw the deceased alive on <i>OCT. 6</i> , 19 <i>57</i> , and that death occurred at <i>6:30 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J.C. Siwinski</i>						ADDRESS (Street, city or town, state) <i>TOWSON 4 108</i>		
						DATE SIGNED <i>DEC 6, 57</i>		
PHYSICIAN'S NAME (Type) <i>T.C. SIWINSKI</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/9/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Pleasant Rest</i>		22d. LOCATION (City, town, or county) <i>TOWSON MD</i>		(State) <i>MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John L. Schatzman - 1701 McClellan St</i>		ADDRESS <i>Baltimore, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>12/10/57</i>		24b. REGISTRAR'S SIGNATURE <i>Mabel Guy</i>		

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12728

12751

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission]	
Baltimore Co MARYLAND		a. STATE Maryland	b. COUNTY Baltimore Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
CATONSVILLE	10 years	BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
Spring Grove State Hosp.	1308 Linden Ave (27)		
3. NAME OF DECEASED (Type or print)	First Harry	Middle M	4. DATE OF DEATH
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
m	N	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	3-15-82
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CLERK	CIVIL. CERV.	LIBERTYTOWN/MD	U.S.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
John W. BUCKEY	Velma RADCLIFFE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES 17-WT	UNKNOWN	RECORD	Spring Grove State Hosp
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
X60X	DUE TO	CEREBRO VASCULAR ACCIDENT 20 min	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last	(b)	GENERAL ARTERIOSKLEROSIS	8 years
	(c)	DIABETES	15 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
HYPERTENSIVE CARDIOVASCULAR DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from July 18, 1953, to 12/15, 1957, that I last saw the deceased alive on 12/15, 1957, and that death occurred at 7 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE	ADDRESS (Street, city or town, state)		
BRUNO RADAUSKAS M.D.	Spring Grove State Hosp. 12/15/57		
PHYSICIAN'S NAME (Type)	DATE SIGNED		
BRUNO RADAUSKAS	Catonsville 28 Md		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
BURIAL	12-19-1957	LORRANE PARK	Woodlawn MD.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Howard Strong	3rd & Water Ave.	DEC 19 1957	DeLoach

BUDEVA  
1957 05

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12723 CERTIFICATE OF DEATH

12729 42  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1228 Maiden Choice Lane		d. STREET ADDRESS 1228 Maiden Choice Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MADORA	Middle BULLOCK	Last 12-22-57
4. DATE OF DEATH Month Year	Day 19		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1863
9. AGE (In years last birthday) 89 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Srill Pond, Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Isaac Dwyer	14. MOTHER'S MAIDEN NAME Susan Apsley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. none	17. INFORMANT Rhoda Brooks, 1223 Maiden Choice Lane	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 a. d. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ 1957 _____, to _____ 1957 _____, that I last saw the deceased alive on _____ Dec 1, 1957, and that death occurred at _____ 7P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED	<i>GEO. S. M. KIEFFER M.D. 1010 Loudon Ave</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-57	22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Ave		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE <i>Dr. Geo. M. Kieffer</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V

DEC 27 1967

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12716 CERTIFICATE OF DEATH

12730

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>	c. LENGTH OF STAY IN 1b <b>5 yrs</b>	b. COUNTY <b>BALTO</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2120 WILLOW SPRING Rd</b>	d. STREET ADDRESS <b>2120 WILLOW SPRING Rd</b>	e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>JACOB W. WILLIAM BURKETT</b>	First <b>J</b>	Middle <b>A</b>	Last <b>BURKETT</b>	4. DATE OF DEATH <b>12-24-57</b>	Month <b>12</b>	Day <b>24</b>	Year <b>57</b>		
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR 15 1909</b>	9. AGE (In years last birthday) <b>48</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTR. FIRMS</b>		11. BIRTHPLACE (State or foreign country) <b>VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JACOB W. BURKETT, S.R.</b>		14. MOTHER'S MAIDEN NAME <b>HILY (DNC)</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>119-01-3054</b>		17. INFORMANT <b>Kathleen M. Burkett — son</b>	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  DUE TO (b)  DUE TO (c)		Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH <b>About 5 yrs.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>a. m.</b>	Month <b>Nov</b>	Day <b>24</b>	Year <b>57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>BALTO</b>	(County) <b>CO</b>	(State) <b>MD</b>	
21. I certify that I attended the deceased from <b>November 1957</b> , to <b>December 24, 1957</b> , that I last saw the deceased alive on <b>December 24, 1957</b> , and that death occurred at <b>2120 Willow Spring Rd</b> . The causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>107 N. Main St., Balto 22 MD</b> DATE SIGNED <b>12/24/57</b>							
NOTARY SIGNATURE <b>J. H. Thomas</b>		M.D.							
PHYSICIAN'S NAME (Type) <b>J. H. Thomas</b>		107 N. Main St., Balto 22 MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12/28/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>OAK LAWN</b>	22d. LOCATION (City, town, or county) <b>BALTO, CO, MD</b>	(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter G. Bradley, Deverell, Jr.</b>		ADDRESS <b>107 N. Main St., Balto 22 MD</b>							
		24a. REC'D BY REGISTRAR <b>DEC 27 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Geo. McRae</b>						

PERIOD V

DEC 29 1977

PERIOD VI

**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12752 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12731

Reg. Dist. No 38

Items 13, 14, 15, 22, 24, 1-14-2 e)

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton		c. LENGTH OF STAY IN 1b		a. STATE Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ruxway Home 7912 Ruxway Road				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4	
3. NAME OF DECEASED (Type or print)		First JAMES	Middle J.	Last BURNS	4. DATE OF DEATH December 21, 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1918	9. AGE (in years 39 years) 10. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conval. Home Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Nursing Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW II 077-12-6976		17. INFORMANT Family records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bullet Wound in Head</i> 476X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Charles F O'Donnell</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>Charles F O'Donnell</i>		DATE SIGNED <i>12/22/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec/23, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Moreland Memorial Park	
22d. LOCATION (City, town, or county) Parkville, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Burns Son</i>		ADDRESS Towson, Md.		24a. REC'D BY REGISTRAR Dec. 23, 1957	
				24b. REG STAR'S SIGNATURE <i>Mabel C. Gray</i>	

BURLAU V. S.

AC 1037

REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12732

12753

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mth16days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville, Maryland	
f. STREET ADDRESS Cedar Lane		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Walter	Middle Melvin	Last Campbell
4. DATE OF DEATH	Month December	Day 11	Year 19 57
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1879
9. AGE (In years lost birthday) 78 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY Ovenier	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Jasper Newton	14. MOTHER'S MAIDEN NAME Sarah Barger		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO Unknown	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }		INTERVAL BETWEEN ONSET AND DEATH	
(b) DUE TO Arteriosclerotic cardiovascular disease			
(c) Arteriosclerosis, generalized			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 21, 19 57, to Dec. 11, 19 57, that I last saw the deceased alive on Dec. 11, 19 57, and that death occurred at 3:30 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Louie Frances Woodward M.D. SPRING GROVE STATE HOSPITAL 12-11-57			
PHYSICIAN'S NAME (Type)		Louie Frances Woodward, M. D. Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 14, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) Bal Air Harford Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard McCormack Abingdon Md.		24a. REC'D BY REGISTRAR DATE DEC 19 '57	
		24b. REGISTRAR'S SIGNATURE John Eich	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REC 19 1957

DEPARTMENT OF  
THE AIR FORCE

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a Burial-Transit Permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE  
HEALTH DEPT.

VS. ATSM  
SM 2/57

4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-Transit Permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12754 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										12733
										Reg. Dist. No. 48
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Colgate</b>					e. STREET ADDRESS <b>306 North Point Road</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Point Blvd. and Eastern Ave.</b>					f. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year	
<b>Perino (Peter)</b>				<b>Campelli</b>	Dec.	8	1957			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5, 1891</b>	9. AGE (in years last b'day) <b>66 yrs</b>		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taylor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturer</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>						
13. FATHER'S NAME <b>Albert Campelli</b>										14. MOTHER'S MAIDEN NAME <b>Anna M. Bonanentera</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>213-05-9430</b>	17. INFORMANT <b>Clementine Campelli</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (b) <b>Fractured Cervical Spine</b>										Address <b>128 S. Bouldin St.</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <b>DUE TO (c) Compound Fracture with Tibia + Fibula at ankles</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1/24</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>Struck by Auto on N. Pt. Blvd at Eastern Ave</b>					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Struck by Auto on N. Pt. Blvd at Eastern Ave</b>					
20c. TIME OF INJURY 24 hrs a.m. on 8/19					20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	20f. CITY OR TOWN <b>Beth - Belo Md</b>	(County) <b>Beth - Belo Md</b>	(State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>M. B. Davis</b>										DATE SIGNED <b>1/18/57</b>
EXAMINER'S NAME (Type) <b>M. B. Davis MD</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 11, 57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State) <b>MD</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Brudzinski</b>					ADDRESS <b>1407 Eastern Ave. #21</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Brudzinski</b>					24a. REC'D. BY REGISTRAR <b>1/18/57</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Brudzinski</b>					24b. REGISTRAR'S SIGNATURE <b>Eliza Hurley</b>					

✓  
RECEIVED

V. S.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12724 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BAL TO</b>	2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission on) b. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>	c. LENGTH OF STAY IN TB c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5554 Link Ave</b>	d. STREET ADDRESS <b>5553 Link Ave</b>		
e. SIRC IDENT. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Blanche P Corback</b>	4. DATE OF DEATH Month <b>12</b> Day <b>26</b> Year <b>1957</b>		
5. SEX <b>7 W</b>	6. COLOR OR RACE 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Dec 1888</b>		
9. AGE (in years on birthday) <b>69 yrs</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Md USA</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	13. FATHER'S NAME <b>William J Houck</b>		
14. MOTHER'S MAIDEN NAME <b>Mollie E (Tunburn)</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>17. INFORMANT</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), <b>stole the underlying cause last.</b> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>GEO S.M. RIEFFER MD</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <b>Dec 28, 57</b>
EXAMINER'S NAME (Type) <b>GEO S.M. RIEFFER MD</b>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Crem</b>	22b. DATE THEREOF <b>12/30/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Towson Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Amber, Inc. 1326 Luthur Spring Rd.</b>	ADDRESS	24a. REC'D. BY REGISTRAR DATE <b>DEC 30 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Dr. Geo M. Kieffer</b>

RECEIVED  
BUREAU Y.

DEC 30 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12735

## 12755 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>MARYLAND</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				c. LENGTH OF STAY IN 1b <b>3 weeks</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PARADISE NURSING HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>EDITH L CARPENTER</b>	Middle	Last	4. DATE OF DEATH <b>12-14-57</b>	Month <b>12</b>	Day <b>14</b>	Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12-14-77</b>			9. AGE (In years last birthday) <b>80</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	13. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>							
13. FATHER'S NAME <b>Daniel Lambdin</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Geoghigan</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Margaret Sherrick, Paradise Nursing Home</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO  Arteriosclerosis Generalized											INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. p. p.m.		Month <b>19</b>	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>12/14/57</b>	(County)	(State)		
21. I certify that I attended the deceased from <b>12/13/57</b> , 19, to <b>12/14/57</b> , 19, that I last saw the deceased alive on <b>12/13/57</b> , 19, and that death occurred at <b>4:45A M</b> , from the causes and on the date stated above.											DATE SIGNED <b>12/14/57</b>
ACTUAL SIGNATURE <b>S. E. Mc Grath</b> PHYSICIAN'S NAME (Type) <b>S. E. Mc Grath M.D.</b>											ADDRESS (Street, city or town, state) <b>1303 Frederick Rd Catonsville, Md.</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-16-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Grace Church</b>			22d. LOCATION (City, town, or county) <b>Taylors Island, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Home, Cambridge, Md.</b>					24a. REC'D BY REGISTRAR <b>Dec 16 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dee LeCompte</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

KLUGER V. R.  
LAW CO.

REINHOLD

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12756 CERTIFICATE OF DEATH

12736

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>.d.</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore suburbs</b>		c. LENGTH OF STAY IN lb <b>7 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7044 Eastbrook Ave.</b>		d. STREET ADDRESS <b>506 S. Streeter St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>GEORGE</b>	Middle <b>W.</b>	Surname <b>CARROLL</b>	4. DATE OF DEATH <b>Dec. 2. 1957</b>	Month <b>Month</b>	Doy <b>Doy</b>	Year <b>Year</b>
5. SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1. 1876</b>	9. AGE (In years lost birthday) <b>81 yrs.</b>	IF UNDER 1 YEAR Months <b>Months</b>	IF UNDER 24 HRS. Hours <b>Hours</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fire Dept. Balto. City. Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Md.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Carroll</b>		14. MOTHER'S MAIDEN NAME <b>Mary Fields</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Frances Carroll (wife) 506 S. Streeter</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>  INTERVAL BETWEEN ONSET AND DEATH <b>4 mo.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town)</b> <b>(County)</b> <b>(State)</b>			
21. I certify that I attended the deceased from <b>August</b> , 19 <b>57</b> , to <b>Dec. 2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec. 1</b> , 19 <b>57</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Eugene Zeller</i>		MD		2739 Eastern Ave. Balto. Md.		<b>12/2/57</b>	
PHYSICIAN'S NAME (Type) <b>Eugene Zeller, M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 5. 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Baltimore Md.</b>		(State)		22e. RECORD BY REGISTRAR <b>REC'D 12/5/57</b>		24b. REGISTRAR'S SIGNATURE <i>Vm. Kelly</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS. INC. Baltimore Md.</b>							

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, part should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 4 1977

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12757 CERTIFICATE OF DEATH

12737  
Reg. Dist. No. 44

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>68 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>228 North Gilmore Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>HARRY</b>	Middle <b>E.</b>	Last <b>COLEBURN</b>	4. DATE OF DEATH <b>December</b>	Month <b>9</b>	Day <b>19</b>	Year <b>57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3, 1913</b>	9. AGE (in years last birthday) <b>44</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Spotter &amp; Presser</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaning</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry Colbourne</b>		14. MOTHER'S MAIDEN NAME <b>Merle Muir</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>214-14-4040</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>THROMBOSIS OF BASILAR ARTERY</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b>					
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last <b>(b)</b>							
DUE TO  <b>(c)</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ACUTE AND CHRONIC PANCREATITIS--DURATION UNKNOWN</b>		19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>					
Operation- 12-2-57 Splenectomy- Necrosis of tail of pancreas							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  <b>VAH</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 2, 1957</b> , to <b>December 9, 1957</b> , <b>CHIEN WEI LAN</b> , and that death occurred at <b>9:05 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Chien Wei Lan</b>		ADDRESS (Street, city or town, state) M.D. <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>12/10/57</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>December 13, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National Cem.</b>		22d. LOCATION (City, town or county) <b>Baltimore, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson, 1000 Brantley Ave., Baltimore, Md.</b>		ADDRESS <b>Elroy O. Wilson, 1000 Brantley Ave., Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>C 13 19</b>		24b. REGISTRAR'S SIGNATURE <b>Hewson L. Farley</b>	

May 20

CC 1057

RECEIVED

## INSTRUCTIONS

**TO A PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A155 10M

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 12759 CERTIFICATE OF DEATH

12738  
33

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Baltimore Butler	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Butler
HOSPITAL OR INST TUTION OR STREET ADDRESS	Falls Rd.	STREET ADDRESS	(If rural give location) Falls Rd.
<b>3. NAME OF DECEASED</b> (First) Anna Gertrude Cole (Type or Print)		<b>4. DATE OF DEATH</b> Dec. 19 1957	
S SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH 9-29-1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY Balto. Plan. Com	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Abijah Cole		14. MOTHER'S MAIDEN NAME Abarilla Tracey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none	17. INFORMANT & ADDRESS Mary E. Mallonee, Butler, Md.
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
II. IMMEDIATE CAUSE (A) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 18 hours	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Arteriosclerotic Cardio-Vascular Disease		10 yrs.	
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from June 18, 1948, to Dec. 19, 1957, that I last saw the deceased alive on Dec. 18, 1957, and that death occurred at 7 A.M. from the causes and on the date stated above.</b>			
SIGNATURE <i>Martin E. Strickel</i>		ADDRESS (Street, city, town, state) M.D. 48 Main St. Reisterstown, Md.	
DATE SIGNED 12-19-57		DATE SIGNED 12-19-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		NAME OF CEMETERY OR CREMATORIUM St. Pauls Lutheran	
24. REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE H. Scott Brody, Towson 4, Md.		LOCATION (City, town, or county) Arcadia, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Mary Elting</i>		ADDRESS	

LEADER V. 8

30

LEADER

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12758 CERTIFICATE OF DEATH

Reg. Dist. No.

127344

## 1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Fort Howard

c. LENGTH OF STAY IN lb

38 Days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

d. STREET ADDRESS

505 South Luzerne Avenue

e. IS RESIDENCE ON A FARM?

YES  NO 3. NAME OF DECEASED  
(Type or print)

First JOHN

Middle G.

Last CHES

4. DATE OF DEATH

Month December

Day 5 Year 1957

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

8. DATE OF BIRTH

March 27, 1921

9. AGE (In years  
from birth to death)

36 yrs

10. IF UNDER 1 YEAR

Months 0 Days 0

11. IF UNDER 24 HRS.

Hours 0 Min 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Crane Operator

10b. KIND OF BUSINESS OR INDUSTRY

Steel Company

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

## 13. FATHER'S NAME

John J. Ches

## 14. MOTHER'S MAIDEN NAME

Helen Golombiewski

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

Yes

(If yes, give war or dates of service)

WW II

16. SOCIAL SECURITY NO.

215-05-2226

17. INFORMANT

Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Maryland

Address

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

LAENNEC'S CIRRHOSIS

INTERVAL BETWEEN  
ONSET AND DEATH

2 YRS. 5 MOS.

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a). Sloting the under-  
lying cause last.

(b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AN AUTOPSY  
PERFORMED?  
YES  NO 

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year  
Hour e. m.  
p. m. 1920d. INJURY OCCURRED  
While  Not while   
of work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that attended the deceased from October 28, 1957, to December 5, 1957, and that death occurred at 7:25 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATUREPHYSICIAN'S  
NAME (Type)

IRVING FREEMAN, M.D., Chief, Medical Service

M.D. VAH, FORT HOWARD, MARYLAND

12/5/57

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

December 9, 1957

22c. NAME OF CEMETERY OR CREMATORIUM

Holy Rosary Cemetery

22d. LOCATION (City, town, or county)

(State)

Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Raymond Kaczorowski, 2525 Fleet Street, Baltimore, MD

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Y. V. MARYA

DEC 19 1968



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12760

## CERTIFICATE OF DEATH

12740

Reg. Dist. No.

41

1. PLACE OF DEATH o COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>35 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3 V 1. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>3023 Windsor Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ROBERT</b>	Middle <b>R.</b>	Last <b>CRAFTON</b>	4. DATE OF DEATH <b>DECEMBER</b>	Month <b>27</b>	Day <b>19</b>	Year <b>57</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1906</b>	9. AGE (In years from birth) <b>51</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS. Days <b>1</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contracting.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elzy Crafton.</b>		14. MOTHER'S MAIDEN NAME <b>Helen Hackler</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO <b>WW II 579-05-3296</b>		17. INFORMANT <b>Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 MONTHS</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF RIGHT KIDNEY WITH METASTASIS TO BONES</b> <b>INDEX AND MESENTERY LYMPH NODES</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the under: lying cause lost. <b>190X</b>		(b) _____ DUE TO _____ (c) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>VAH Fort Howard</b>	(County) <b>Maryland</b>
21. I certify that I attended the deceased from <b>November 22, 1957, to December 27, 1957.</b> and that death occurred at <b>3:00 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Chien Wei Jan</i>		M.D.		ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Maryland</b>		DATE SIGNED <b>12/26/57</b>	
PHYSICIAN'S NAME (Type) <b>CHIEN WEI JAN, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-31-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>	22d. LOCATION (City, town, or county) <b>5501 Frederick Ave., Balto., Md.</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Blight Jr.</i>		ADDRESS <b>6009 Harford Road</b>	24a. REC'D BY REGISTRAR DATE <b>12/31/57</b>	24b. REGISTRAR'S SIGNATURE <i>Garrison L. Parker</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Pyne V. S.

DEC 34



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12761 CERTIFICATE OF DEATH

Reg. Dist. No. 1274144

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>6 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa</b>		d. STREET ADDRESS <b>Box 511, Rt. 2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>HARRY</b>	Middle <b>V.</b>	Last <b>CULVER</b>	4. DATE OF DEATH <b>December</b>	Month <b>11</b>	Day <b>19</b>	Year <b>57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 25, 1896</b>	9. AGE (in years from last birthday) <b>61</b>	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS Days <b>1</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building construction</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles E. Culver</b>		14. MOTHER'S MAIDEN NAME <b>Emma Marshall</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WW I 218-07-9273</b>		17. INFORMANT <b>Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH WITH METASTASES TO LIVER XXIX AND ABDOMINAL LYMPH NODES</b> 151X						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under: DUE TO (b) (c) lying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Operation-Gastrectomy (partial) with gastrojejunostomy-Johns Hopkins Hospital-Recent.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 5, 1957, to December 11, 1957, <b>XXXXXX</b> , and that death occurred at 7:45 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Chien Wei-Lan</i>						ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-16-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook Blight, Inc.</i>		ADDRESS <b>6009 Harford Rd., Baltimore, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>12/18/57</b>		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Farley</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNIVERSITY OF TORONTO LIBRARIES

DEC



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12717 CERTIFICATE OF DEATH

Reg. Dist. No.

12748

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		b. COUNTY <b>Baltimore</b>		
c. LENGTH OF STAY IN 1b <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1732 Brookview Rd. #22</b>		d. STREET ADDRESS <b>1732 Brookview Rd. #22</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>MARY</b>	First <b>E.</b>	Middle <b>CUTTINS</b>	Last <b>December</b>	
4. DATE OF DEATH <b>29, 1957.</b>	Month <b>December</b>	Day <b>29</b>	Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 5, 1883</b>	
9. AGE (In years lived/birthday) <b>74 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John J. Smith</b>	14. MOTHER'S MAIDEN NAME <b>Susan Bozman</b>	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Edward H. Cummins Sr.</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO <b>YEARS</b> (c)	INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATELY</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>29 DEC</b> , 1957, to <b>29 DEC</b> , 1957, that I last saw the deceased alive on <b>29 DEC</b> , 1957, and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>33 DUNDALK AVE</b> DATE SIGNED <b>1-1-57</b>				
ACTUAL SIGNATURE <b>W.E. Baermann</b>	PHYSICIAN'S NAME (Type) <b>W.E. Baermann, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1-2-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>OAK LAWN CEM.</b>	22d. LOCATION (City, town, or county) <b>7225 EASTERN BLVD., MO.</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Seiler</b>	ADDRESS <b>901 S. CONKLING ST.</b>	24a. REC'D BY REGISTRAR <b>1/2/58</b>	24b. REGISTRAR'S SIGNATURE <b>Mr. Kelly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12762 CERTIFICATE OF DEATH

12743

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Pr. Seeger ✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE</b>		d. STREET ADDRESS <b>5814 Quintana Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <b>MALCOLM.</b>	Middle <b>CHARLES</b>	Last <b>DAUGHERTY</b>	4. DATE OF DEATH	Month <b>12</b>	Day <b>25</b>	Year <b>1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12-6-99.</b>	9. AGE (In years last birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSES - SELF</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES W. DAUGHERTY</b>		14 MOTHER'S MAIDEN NAME <b>MARGARET GILL</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>UNKNOWN</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> 20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-25-1956</b> to <b>12-25-1957</b> , that I last saw the deceased alive on <b>12-25-1957</b> , and that death occurred at <b>4:45 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>William Newcomer</b> M.D. Mt. Wilson, Maryland		ADDRESS (Street, city or town, state) <b>12-25-57</b>		DATE SIGNED <b>12-25-57</b>			
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		Superintendent		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/28/57</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>* Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>D. E. G. S. J.</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Powell</b>	

BUREAU V. S.

JEC 7/1/1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12763 CERTIFICATE OF DEATH

12763  
M

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL—PHOENIX</b>	c. LENGTH OF STAY IN 1b <b>20 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL—PHOENIX MD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHILPOT ROAD</b>	d. STREET ADDRESS <b>PHILPOT ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>MILTON</b>	First <b>M</b>	Middle <b>E.</b>	Last <b>DAVIS</b>
4. DATE OF DEATH <b>Dec 15 1957</b>	Month	Day	Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Milton Davis</b>	14. MOTHER'S MAIDEN NAME <b>Unknown</b>	Address <b>Miss Mary Dashiell 4202 Roland Ave. Balto. Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>241X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> DUE TO <b>(c)</b> asthma and chronic bronchitis
			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>NONE</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year p. m.			
21. I certify that I attended the deceased from <b>August 1957</b> to <b>Dec 1957</b> , that I last saw the deceased alive on <b>December 1957</b> , and that death occurred at <b>2:55 AM</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>David H. Marine</b>	M.D.	ADDRESS (Street, city or town, state) <b>1733 BULTON ST BALTIMORE 17</b>	DATE SIGNED <b>12/15/57</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Dec. 18, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Pine Grove</b>	22d. LOCATION (City, town, or county) Dist. <b>City</b> (State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>	ADDRESS <b>1900 Eutaw Pl. Balt</b>	REC'D BY REGISTRAR DATE <b>DEC 15 1957</b>	REGISTRAR'S SIGNATURE <b>Ely Gorsuch</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12764 CERTIFICATE OF DEATH

127451

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>		c. LENGTH OF STAY IN 1b <i>3 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>		d. STREET ADDRESS <i>13506 Chapman Road</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Christian</i>	Middle <i>J. M.</i>	Last <i>Delker</i>	4. DATE OF DEATH Month <i>Dec.</i> Day <i>3</i> Year <i>1957</i>				
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 3, 1892</i>	9. AGE (In years, months, days) 65 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>H. H. Woodlark</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Charles M. Delker</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth E. Easter</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO <i>215-10-9672</i>		17. INFORMANT <i>Florence Delker</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE PULMONARY CONGESTION</i> DUE TO 460-1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>0228</i>						INTERVAL BETWEEN ONSET AND DEATH —			
(b) <i>MYOCARDIAL FAILURE</i> DUE TO						2 DAYS			
(c) <i>C-H DISEASE &amp; ARTERIO SCLEROSIS</i>						6 YRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>PULMONARY TUBERCULOSIS AND CADANGIA</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day Not while at work <input type="checkbox"/>	Year at work <input type="checkbox"/>	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <i>Nov. 30</i> , 1957, to <i>Dec. 3</i> , 1957, that I last saw the deceased alive on <i>Dec. 2</i> , 1957, and that death occurred at <i>M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Harold H. Weinstock M.D.</i> PHYSICIAN'S NAME (Type) <i>HAROLD H. WEINSTOCK M.D.</i>						ADDRESS (Street, city or town, state) DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec. 6, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Fondon Park Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harold H. Weinstock</i>		ADDRESS <i>8728 Liberty Road.</i>	24a. REC'D BY REGISTRAR <i>DEC 13 1957</i>	24b. REGISTRAR'S SIGNATURE <i>John Masterson</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician by the funeral director. To Fun Director: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12746

## 12765 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1805 Penrose Avenue</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>OSCAR</b>		First	Middle <b>--</b>	Last <b>DICKEY</b>	4. DATE OF DEATH <b>December 12 1957</b>	Month <b>December</b>	Day <b>12</b>	Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 10, 1895</b>	9. AGE (In years last birthday) <b>62 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>62</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>					
8. MARITAL STATUS WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Lynchburg, South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Nelson Dickey</b>		14. MOTHER'S MAIDEN NAME <b>Tina McGill</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WW I 213-09-3901</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>X</b> <b>CEREBRAL HEMORRHAGE, LEFT</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO <b>BRONCHOPNEUMONIA, BILATERAL</b>						UNKNOWN					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Operations: 1. Tracheostomy 2. Bilateral trephining. Date 12/6/57</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>441X</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH, FORT HOWARD, MARYLAND</b>	20f. (City or town) <b>VAH, FORT HOWARD, MARYLAND</b>	(County) <b>VAH, FORT HOWARD, MARYLAND</b>	(State) <b>MD</b>
21. I certify that I attended the deceased from <b>December 5, 1957</b> to <b>December 12, 1957</b> , and that death occurred at <b>5:00 AM</b> , from the causes and on the date stated above.								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles J. Farley</b>								DATE SIGNED <b>12/12/57</b>			
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-17-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State) <b>MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Farley</b>		ADDRESS <b>802 1/2 Madison Ave Balto. Md</b>		24a. REC'D BY REGISTRAR <b>12/16/57</b>		24b. REGISTRAR'S SIGNATURE <b>Samuel J. Farley</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12766 CERTIFICATE OF DEATH

12742

**Reg. Dist. No**

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b>			MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) o. STATE <b>Maryland</b>	Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville Rural</b>		c. LENGTH OF STAY IN lb <b>62 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville Maryland Rural</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Belair Road Kingsville, Md.</b>		d. STREET ADDRESS <b>Belair Road Kingsville, Md.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Mary M. Dilworth</b>	First	Middle	Last	4. DATE OF DEATH Month <b>12</b>	Day <b>14</b> Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/30/1874</b>	9. AGE (In years last birthday) <b>83</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country)* <b>Harford Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Gilpin O. Hutton</b>		
14. MOTHER'S MAIDEN NAME <b>Frances M. Kirk</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> If yes, give war or date of service <b>no</b>		
16. SOCIAL SECURITY NO			17. INFORMANT Address <b>Mr. Carl B. Temple Kingsville, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> DUE TO <b>(c)</b> CONGESTIVE HEART FAILURE 4 mos. HYPERTENSIVE CARDIOVASCULAR DIS. 20 yrs.					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTROPHIC CARDIOMYOPATHY</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>---</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>FORK MD.</b>	(County) <b>FORK</b>	(State) <b>MD.</b>
21. I certify that I attended the deceased from <b>NOV. 1, 1956</b> , to <b>12-14, 1957</b> , that I last saw the deceased alive on <b>12-14, 1957</b> , and that death occurred on <b>12-14, 1957</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Clifford F. Hudson</b>			ADDRESS (Street, city or town, state) <b>FORK MD.</b>		
PHYSICIAN'S NAME (Type) <b>CLIFFORD F. HUDSON</b>			DATE SIGNED <b>12-14, 1957</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>12/18/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>St. John's Episcopal</b>	22d. LOCATION (City, town, or county) <b>Kingsville, Maryland</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lorraine Funeral Home 740 Belair Rd.</b>			24a. ADDRESS <b>740 Belair Rd.</b>	24b. REC'D BY REGISTRAR <b>REC'D 12-18-57</b>	24b. REGISTRAR'S SIGNATURE <b>Dr. W. Kennedy</b>

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12767 CERTIFICATE OF DEATH

Reg. Dist. No.

12748

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-troull permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>BALTO.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>BALTO.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATONSVILLE</i>		c. LENGTH OF STAY IN 1b <i>84m.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATONSVILLE</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>401 Oak Forrest Ave</i>		d. STREET ADDRESS <i>401 Oak Forrest Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>LILLIE</i>		First <i>L</i>	Middle <i>I</i>	Last <i>DONOVAN</i>	4. DATE OF DEATH <i>12/28 1957</i>	Month <i>12</i>	Day <i>28</i>	Year <i>1957</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN. 1, 1870</i>	9. AGE (In years last birthday) yrs. <i>87</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>V. S. A.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ireland</i>		11. BIRTHPLACE (State or foreign country) <i>Irland</i>		12. CITIZEN OF WHAT COUNTRY? <i>V. S. A.</i>				
13. FATHER'S NAME <i>James Maguire</i>		14. MOTHER'S MAIDEN NAME <i>Mary Abbott</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>				
17. INFORMANT <i>Mac M. Sherwood - (same)</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>If it's</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the under-lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>						
20. MEDICAL CERTIFICATION		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>614 Edmondson Ave. Balt. MD</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>MD</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>Oct. 18, 1957</i> to <i>Dec. 28, 1957</i> , that I last saw the deceased alive on <i>Dec. 28, 1957</i> , and that death occurred at <i>9:00 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>614 Edmondson Ave. Baltimore MD</i>		DATE SIGNED <i>12/28/57</i>						
ACTUAL SIGNATURE <i>J. Nelson McKay</i>		PHYSICIAN'S NAME (Type) <i>J. Nelson McKay, M.D.</i>		22d. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/31/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Gordon Park</i>	22d. LOCATION (City, town, or county) <i>Baltimore</i>	(State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mac Mabb &amp; Son</i>		ADDRESS <i>28</i>		24a. REC'D BY REGISTRAR <i>DEC 31 1957</i>		24b. REGISTRAR'S SIGNATURE <i>John J. O'Connor</i>				

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12768 CERTIFICATE OF DEATH**

12749  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. II institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4yrlmth12dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C., Hillside</b>	
3. NAME OF DECEASED (Type or print) <b>Archie Nelson</b>		d. STREET ADDRESS <b>1108 - 58th Avenue</b>	
3. SEX <b>male</b>		4. DATE OF DEATH <b>December 27 1957</b>	
6. COLOR OR RACE <b>white</b>		5. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. DATE OF BIRTH <b>June 29, 1899</b>		8. AGE (in years from birthday) <b>58 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>construction worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Records: SPRING GROVE STATE HOSPITAL</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>W. J. Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Anderson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-03-9172</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Infarctive myocardial fibrosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
47.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Arteriosclerotic cardiovascular disease			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Regional ileitis</b>		19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Spring Grove</b> (County) <b>Prince George's Co.</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Oct. 17, 1957</b> , to <b>Dec. 27, 1957</b> , that I last saw the deceased alive on <b>Dec. 27, 1957</b> , and that death occurred at <b>3:15 a.m.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>12-27-57</b>	
ACTUAL SIGNATURE <i>Stella Wachsler</i>		M.D.	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/30/57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) <b>Prince Georges Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Kines Co. P.W. Washington</i>		24a. REC'D BY REGISTRAR <b>REC'D 30 57</b>	
ADDRESS <b>2901-19th</b>		24b. REGISTRAR'S SIGNATURE <b>REC'D 30 57</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEC 30 1957

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12769

## CERTIFICATE OF DEATH

1275B8

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		12769 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1509 Taylor Ave		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. UNDER 1 YEAR Months	11. Days	12. UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
18. CAUSE OF DEATH. [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARCINOMA, LUNG				6 MONTHS		
DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)								
DUE TO								
(c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from 15 DEC 1957, to 25 DEC 1957, that I last saw the deceased alive on 25 DEC 1957, and that death occurred at 2:45 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE: MARY E. BROWN								
PHYSICIAN'S NAME (Type): Loch R. Shopping Center								
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town or county)		(State)
23. FUNERAL DIRECTOR'S SIGNATURE: MARY E. BROWN		ADDRESS: 1509 Taylor Ave		24a. REC'D BY REGISTRAR: REC'D 31151		24b. REGISTRAR'S SIGNATURE: M. Brown		

REVIEW

DEC 19 1968

2000

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12770

Item 7 F-1-3223 12-24-57 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

12751

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b <b>54</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>297 Montrose Avenue</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH</b>		First <b>JOSEPH</b>	Middle <b>JAMES</b>
Last <b>EKR</b>		4. DATE OF DEATH <b>Dec. 14, 1957</b>	Month <b>Dec.</b>
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
		WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Sept. 14, 1876</b>		9. AGE (in years less birthday) <b>81 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>
			Days <b>0</b>
			Hours <b>0</b>
			Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cooper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kimble-Tyler</b>	11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>213-01-3105A</b>	17. INFORMANT <b>Frank Ekr, son, above</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		Address	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
Coronary occlusion arteriosclerotic Cardio Vascular renal disease		1 yr	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 1, 1957</b> to <b>Dec. 14, 1957</b> , that I last saw the deceased alive on <b>Dec. 14, 1957</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>G. M. Baumgardner, M.D.</b>		ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type) <b>G. M. Baumgardner, M. D.</b>		DATE SIGNED <b>12/17/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/17/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Oak Hill Gem.</b>
22d LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc. 2001 E. Madison St.		24a. REC'D BY REGISTRAR <b>DEC 19 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Edith Hanley</b>

REPORT NO. 8

25

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12771 CERTIFICATE OF DEATH

12752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>520 Morris Ave.</b>		e. STREET ADDRESS <b>520 Morris Ave.</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Ethel</b>	Middle <b>Morgan</b>	Last <b>Elliott</b>
4. DATE OF DEATH	Month <b>Dec</b>	Day <b>1</b>	Year <b>1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-1912</b>
9. AGE (In years at birthday) <b>45</b>	10. IF UNDER 1 YEAR; IF UNDER 24 HRS yrs. <b>Months</b>	11. IF UNDER 1 YEAR; IF UNDER 24 HRS Days <b>Hours</b>	12. IF UNDER 1 YEAR; IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>	
10c. BIRTHPLACE (State or foreign country) <b>Maryland</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry T. Elliott</b>		14. MOTHER'S MAIDEN NAME <b>Eva Shepperd</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>215-05-2052</b>	
17. INFORMANT <b>Mrs. Virginia Einstein, 201 N. Beechwood</b>		Address <b>Baltimore, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the ovary</b>		INTERVAL BETWEEN ONSET AND DEATH	
19. DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>175X</b>			
20. DUE TO  (b)			
21. DUE TO  (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Greene</b> , 1957, to <b>Dec. 1</b> , 1957, that I last saw the deceased alive on <b>Dec. 1</b> , 1957, and that death occurred at <b>3rd &amp; Park</b> , M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Parkway, Md.</b>			
ACTUAL SIGNATURE  <b>A. M. France</b>		DATE SIGNED <b>12/2/57</b>	
PHYSICIAN'S NAME (Type)  <b>A. M. France</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-4-57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>St. James Episcopal</b>		22d. LOCATION (City, town, or county) <b>Monkton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE  <b>L. Scott Brooks</b>		24a. REC'D BY REGISTRAR DATE DEC 3 '57	
ADDRESS <b>622 York Rd., Towson, Md.</b>		24b. REGISTRAR'S SIGNATURE  <b>D. L. Smith</b>	

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HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the record prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12772 CERTIFICATE OF DEATH

12753

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4211 Darnell Ave.		d. STREET ADDRESS 118 N. Port St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MABEL	First F.	Middle ELLOFF	4. DATE OF DEATH Month December Day 3, Year 19 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 31, 1905
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Emil Radke		14. MOTHER'S MAIDEN NAME Katherine Neiberding	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Address William Elloff - 118 N. Port St.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1/ hour	
(a) Cerebral Thrombosis, Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		3	
(b) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Genito Urinary tract Infection			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. s. p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from 11-15, 1957, to 12/3, 1957, that I last saw the deceased alive on 12-3, 1957, and that death occurred at 6:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul G Mueller	M.D.	ADDRESS (Street, city or town, state) 6331 Belair Rd	DATE SIGNED
PHYSICIAN'S NAME (Type) PAUL G MUELLER M.D.	Balt. & Md		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 6, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Parkwood	22d. LOCATION (City, town, or county) (State) Parkville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.	ADDRESS	24a. REC'D. BY REGISTRAR DEPT. 12/4/57	24b. REGISTRAR'S SIGNATURE Dr. Walter Hammett

PURNAU V. S

DEC 1 1968

KODAK SAFETY FILM

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12754

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodlawn</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>xo Woodlawn</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6836 Dogwood Road</i>		e. STREET ADDRESS <i>6836 Dogwood Rd.</i>	
f. FIRST MIDDLE LAST <i>George E. Euler</i>		4. DATE OF DEATH Month Day Year <i>Dec. 19 1957</i>	
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 5, 1886</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter (retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Schirner (Chas)</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Co.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Euler</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Younger</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-03-0798</i>	
17. INFORMANT <i>Mrs. Viola Euler - 6836 Dogwood Rd.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>multiple myeloma</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertrophic arthritis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> Not white p. m. <i></i> at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>14 Feb 1957</i> to <i>19 Dec 1957</i> , that I last saw the deceased alive on <i>13 Dec 1957</i> , and that death occurred at <i>4 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Woodlawn</i> DATE SIGNED <i>Charles P. Williams</i> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec. 21, '57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Lorraine Park</i>		22d. LOCATION (City, town, or county) <i>Woodlawn</i> <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Stansbury - 6411 Windsor Mill Rd.</i>		24a. REC'D. BY REGISTRAR DATE <i>Dec. 21 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>John Wm. Martin</i>	

HOSPITAL ATTENDANT: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to the burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12774

## CERTIFICATE OF DEATH

Reg. Dist. No. 12755

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o STATE Maryland b COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix, Maryland	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS Phoenix, Maryland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edna	Middle Pearl	Last Evans
4. DATE OF DEATH Dec.	Month 1/	Day 17	Year 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887 Dec. 4, 1887
9. AGE (in years last birthday) 98 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife, part time Hospital			
10b. KIND OF BUSINESS OR INDUSTRY Hospital			
11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Harry Fischer		14. MOTHER'S MAIDEN NAME Win. Harrison Fisher Pierce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO 214-14-0406	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4d-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Decompensated Cardiovascular illness 23 days</u> DUE TO (c) <u>advanced arteriosclerotic generalized cond. unknown</u>			
INTERVAL BETWEEN ONSET AND DEATH 40 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic brain syndrome due to arteriosclerosis, Parkinson's syndrome</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 7, 1957, to Dec. 17, 1957, that I last saw the deceased alive on Nov. 30, 1957, and that death occurred at 8 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Gertrude J. Fleischmann</u> M.D. SPRING GROVE STATE HOSPITAL DATE SIGNED Dec 17 1957			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-3-57	22c. NAME OF CEMETERY OR CREMATORIAL Towson Cemetery
22d. LOCATION (City, town or county) Chestertown		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Brooks Funeral Service 620 York Rd., Catonsville		24a. REC'D REGISTRAR REGS 57	24b. REGISTRAR'S SIGNATURE L. Creek
		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it could be detached for use as the burial permit. Then please remove carbon paper. Page 2 should be filed with the hospital or prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

S. A. GAYLORD H.

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GOVERNOR V. C.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12776

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

127574  
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in cert. date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PHA3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-Visitation Permit. File pages 1 and 2 with the Board of Health, or my designated agent, prior to burial, cremation, or removal, and in any event within 22 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4303 Soth Avenue</b>		d. STREET ADDRESS <b>4303 Soth Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>CHARLES</b>	Last <b>FARMER</b>	4. DATE OF DEATH <b>December 9 1957</b>	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27, 1888</b>	9. AGE (in years last birthday) <b>68 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Beer Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>James Farmer</b>		14. MOTHER'S MAIDEN NAME <b>Eupha Maxwell</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-03-2470</b>		17. INFORMANT <b>Miss Eupha R. Muller, 4303 Soth Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)  DUE TO (c)		Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Paul F. Guerin</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/10/57</b>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 12/13/57</b>			
22b. DATE THEREOF <b>12/13/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>New Cathedral Cem</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Ma.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5305 Harford Road #14</b>		ADDRESS <b>Leonard J. Ruck 5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 17 1957</b>	
				24b. REGISTRAR'S SIGNATURE <i>Walter Ammett</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12777

## CERTIFICATE OF DEATH

12758 33  
Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ROSEWOOD, ANN ARBOR MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL	c. LENGTH OF STAY IN lb	b. COUNTY Baltimore	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROSEWOOD TRAINING SCHOOL	e. STREET ADDRESS 4710 DOWNSIDE PL.	d. STREET ADDRESS 4710 DOWNSIDE PL.		
3. NAME OF DECEASED (Type or print)	First JULIE	Middle KAREN	Last LARKE	
4. DATE OF DEATH 2	Month 2	Day 13	Year 1957	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/11/36	
9. AGE (In years from birthday) yrs 10	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John L. Ferrell	14. MOTHER'S MAIDEN NAME Shirley inuse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. H016	17. INFORMANT Rosewood Records	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diarrhea &amp; acidosis and dehydration</u> DUE TO <u>one month</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>E Coli and Proteus infections</u> DUE TO <u>one month</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mongolism</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____		
20c. TIME OF INJURY Hour o. m. p. m.	Month Dec 18 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rosewood State Jr. School	(County) (State)
21. I certify that I attended the deceased from <u>Dec 8, 1957</u> , to <u>Dec 13, 1957</u> , that I last saw the deceased alive on <u>Dec 13, 1957</u> , and that death occurred at <u>3:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Rosewood State Jr. School DATE SIGNED 12/14/57				
ACTUAL SIGNATURE <u>Viola B. Johns</u>	PHYSICIAN'S NAME (Type) <u>Viola B. Johns</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 16, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Balto. Nat. Cem. BALTO. Maryland	22d. LOCATION City, town, or county BALTO. Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Truman Schwalb</u>	ADDRESS 3512 Frederick Ave (29)	24a. REC'D BY REGISTRAR D DATE 12/14/57	24b. REGISTRAR'S SIGNATURE <u>Mary Bling</u>	

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm P.M.3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a Burial-Irritants Permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12778 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institutional, residence before admission, b. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b>		c. LENGTH OF STAY IN lb <b>27 yrs.</b>		d. STREET ADDRESS <b>Woodbine Ave.</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>401 Woodbine Ave.</b>		f. FIRST MIDDLE LAST <b>Clara Brooks Fishpaw</b>		g. DATE OF DEATH <b>12-6</b>		Month	Day	Year	
3. NAME OF DECEASED (Type or print) <b>Clara Brooks Fishpaw</b>		h. COLOR OR RACE <b>white</b>		i. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> j. DATE OF BIRTH <b>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 10-2-1876</b>		Age (in years less birthday) <b>81</b>	IF UNDER 1 YEAR Months <b>12</b>	IF UNDER 24 MONTHS Days <b>6</b>	IF UNDER 24 HRS Hours <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>director</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>public schools</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Robert. Fishpaw</b>		14. MOTHER'S MAIDEN NAME <b>Laura Brooks</b>		Address <b>John A. Horn, 401 Woodbine Ave., Towson 4, Md.</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>John A. Horn, 401 Woodbine Ave., Towson 4,</b>		18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <b>DUE TO</b> <b>(c)</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Bronchial Pneumonia</b> <b>Chronic De Compensation</b> <b>Hypertension</b> <b>Malnutrition</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-9-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Jessops Methodist</b>		22d. LOCATION (City, town, or county) <b>Sparks, Md.</b>		DATE SIGNED <b>12/7/57</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>I. Scott Brooks</b>		24a. REC'D BY REGISTRAR DATE <b>4-16-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>					

BUREAU V. S.

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ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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12779

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b>		b. COUNTY <b>Maryland</b>	
c. LENGTH OF STAY IN 1b <b>4 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XI Randallstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Robt Nursing Home Essex Road Balto 7</b>		d. STREET ADDRESS <b>9119 Liberty Road</b>	
e. IS RESIDENCE ON A FARM <b>NO</b>		e. IS RESIDENCE ON A FARM <b>NO</b>	
3. NAME OF DECEASED (Type or print)	First <b>Georgia</b>	Middle <b>Pearce</b>	Last <b>Fite</b>
4. DATE OF DEATH	Month <b>Dec.</b>	Day <b>23.</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>April 14, 1866</b>
8. AGE (In years lost birth) <b>91</b>		9. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto., Co; Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William E. Fite</b>		14. MOTHER'S MAIDEN NAME <b>Mary Choate</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>*****</b>	
17. INFORMANT <b>Miss. Kitty C. Fite 9119 Liberty Road</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral-Vascular accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>422.2</b>			
(b) <b>Hypertension C.V. disease &amp; Kidney</b>		10 years	
DUE TO (c) <b>Damage &amp; Chronic Lung Heart Failure</b>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE 1, 1957</b> to <b>DEC 23, 1957</b> , that I last saw the deceased alive on <b>DEC 23, 1957</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Randallstown Md</b>	
ACTUAL SIGNATURE <b>Thomas E. Steele</b>		DATE SIGNED <b>7/25/57</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/26/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Mt. Zion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Holabrook Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Horning Byers 8728 Liberty Road</b>		24a. REC'D BY REGISTRAR DATE <b>Jan 2 1958</b>	
		24b. REGISTRAR'S SIGNATURE <b>Edith Burley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and on any event within 72 hours after death.

RECEIVED  
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BUTTER V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12780

## CERTIFICATE OF DEATH

12761  
38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN lb <b>Life</b>		d. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1835 White Oak Rd.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		f. STREET ADDRESS <b>1835 White Oak Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>PETER</b>		First <b>W.</b>	Middle <b>FLANNERY</b>	Lost <b>1876</b>	4. DATE OF DEATH <b>DECEMBER 24</b>
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>1876</b>	9. AGE (in years lost birthday) <b>81</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Piano Tuner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Richard Flannery</b>		14. MOTHER'S MAIDEN NAME <b>Briget Slavin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Yes</b>		17. INFORMANT <b>Mrs. Joseph Mertin 1835 White Oak Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <b>Cerebrovascular disease</b> 2 yrs?			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b)  DUE TO  (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-18</b> , 19 <b>57</b> , to <b>12-4-57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12-23</b> , 19 <b>57</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE 		ADDRESS (Street, city or town, state) <b>JOSEPH SKLOVEN, M. D.</b> <b>7122 Harford Road</b> <b>Baltimore 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVED (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/27/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>New Cathedral Cemetery</b>	
22d. LOCATION (City, town or county) (State)		22e. LOCATION (City, town or county) (State)			
23 FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran - 3000 E. Baltimore St.</b>		24a. ADDRESS <b>John A. Moran - 3000 E. Baltimore St.</b>		24b. REC'D BY REGISTRAR <b>DEC 27 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Dr. A.M. Bacon</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

. 12781 CERTIFICATE OF DEATH

12762  
Reg. No. 12762

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b 11 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 330 Murdock Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ella Cecelia Brengle Flautt	First Middle Last	4. DATE OF DEATH Dec. 12	Month Day Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRITAL STATUS WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 10, 1877			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min			
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George Brengle		14. MOTHER'S MAIDEN NAME Elizabeth Eckstein				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH  Arterioscler. Cardio vascular disease Arteriosclerosis, severe				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Dec. 6, 1957, to Dec. 12, 1957, that I last saw the deceased alive on Dec. 12, 1957, and that death occurred at 6:45 P.M. from the causes and on the date stated above.						
ACTUAL SIGNATURE STELLA WACHSLER, M.D.	ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			DATE SIGNED 12/12/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-1957		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		W.	ADDRESS Frederick Md.	24a. REC'D BY REGISTRAR DATE 12-16-1957	24b. REGISTRAR'S SIGNATURE Quinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director,  
 it should be detached for use as the burial-transit permit. Then please remove carbon papers. Nos. 1 and 2 should be certified with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12782 CERTIFICATE OF DEATH

1276328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>BALTO</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PARKVILLE</i>		c. LENGTH OF STAY IN 1b <i>LIFE</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8623 WINDLE Ave</i>		e. STREET ADDRESS <i>18623 WENDELL Ave</i>				
3. NAME OF DECEASED (Type or print) <i>ROY</i>		4. DATE OF DEATH Month <i>Dec</i>	Day Year <i>26 1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 13 1894</i>			
9. AGE (In years last birthday) yrs. <i>63</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FINANCIAL</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>PAPER - HARTFORD</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <i>MURTEL Founds SAME</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>217-01-4568</i>	17. INFORMANT Address <i>MURTEL Founds SAME</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>one year</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Moreland Manor, Md</i>	20f. (City or town) <i>BALTO</i>	(County) <i>Md</i>	(State)
21. I certify that I attended the deceased from <i>June 20, 1957</i> to <i>Dec. 26, 1957</i> that I last saw the deceased alive on <i>Dec. 26, 1957</i> , and that death occurred at <i>9:15 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state), <i>6217 Harford rd Ext. 14</i>		DATE SIGNED <i>12-26-57</i>		
ACTUAL SIGNATURE <i>J. M. Facons</i>		PHYSICIAN'S NAME (Type) <i>J. M. Facons</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL Dec 30-1957</i>		22b. DATE THEREOF <i>Dec 30-1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Moreland Manor, Md</i>		22d. LOCATION (City, town or county) <i>BALTO</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chas T Evans &amp; Son</i>		ADDRESS <i>8802 Harford Rd</i>		24a. REC'D BY REGISTRAR DATE <i>C. J. G. 12-26-57</i>	24b. REGISTRAR'S SIGNATURE <i>J. M. Facons</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12764  
33

## 12783 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>QuINNS MILLS</b>	c. LENGTH OF STAY IN 1b <b>24 YEARS</b>	b. COUNTY <b>HARPOD</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - ABERDEEN</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood STATE TRAINING School</b>	d. STREET ADDRESS <b>Box 41</b>	d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LUCINDA JENE FRANKO</b>	First Middle Last	4. DATE OF DEATH <b>DECEMBER 31 1957</b>	Month Day Year		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 26, 1924</b>		
9. AGE (In years lost birthday) 33 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>STEPHEN FRANKO</b>		14. MOTHER'S MAIDEN NAME <b>ALICE M. WRIGHT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>No</b>		16. SOCIAL SECURITY NO _____			
17. INFORMANT <b>Rosewood Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Possible Cardiac Failure</b> <b>325.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Secondary Anemia</b> DUE TO (c) <b>Mongolism</b>					
INTERVAL BETWEEN ONSET AND DEATH <b>5 Minutes</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>31 Dec 1957</b> , to <b>31 Dec 1957</b> , that I last saw the deceased alive on <b>31 Dec 1957</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Clowings Mills, MD 20740</b>	
ACTUAL SIGNATURE <b>Starry G. Butler M.D.</b>				DATE SIGNED <b>Dec 1957</b>	
PHYSICIAN'S NAME (Type)					

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>1/3/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>	22d. LOCATION (City, town, or county) <b>Hanover, Hanover, MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James G. Butler, Hanover Line</b>	ADDRESS <b>110 Main Street, Hanover, MD 21078</b>	24a. REC'D BY REGISTRAR <b>REG'D 1/3/57</b>	24b. REGISTRAR'S SIGNATURE <b>Terry Elmes</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filled in by the registrar prior to burial, cremation, or removal, and may event within 72 hours after death.

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REGEAU V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12765

12784

38

## CERTIFICATE OF DEATH

Rev. Dist. No.

THIS IS A PERMANENT RECORD.  
PLEASE TYPE OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.  
Every item of information (be carefully supplied. Physicians: please write the causes of death clearly and legible)  
THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTEI

1. NAME OF DECEASED (Type or Print)		ABbie H. FRENCH		2. DATE OF DEATH Dec. 19, 1957
3. PLACE OF DEATH: A. <del>MARYLAND</del> Maryland TOWSON		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
B. FULL NAME OF HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <i>Baltimore County</i>		A. STATE Md.		
C. CITY OR TOWN <i>Towson</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
D. STREET ADDRESS <i>407 Donegal Drive</i>		D. STREET ADDRESS (If rural, give location)		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH June 15, 1865	9. AGE (In years last birthday) 92 M Under 1 Year Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>New Hampshire</i>	
13. FATHER'S NAME <i>Edward Luther Hall</i>		14. MOTHER'S MAIDEN NAME <i>Helen Marr Walker</i>		12. CITIZEN OF WHAT COUNTRY?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/> no		16. SOCIAL SECURITY NO none	17. INFORMANT Mrs. Helen M. Hall - 407 Donegal Drive	
ADDRESS				
INTERVAL BETWEEN ONSET AND DEATH				
CAUSE OF DEATH				
<p><i>Pulmonary edema</i>      <i>7 days</i></p> <p><i>Arteriosclerotic cardio-vascular disease</i></p> <p><i>Paralysis disease</i></p>				
ANTECEDENT CAUSES				
<p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>(A) DUE TO</p> <p>(B) DUE TO</p> <p>(C) DUE TO</p>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT				
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>Dec 19 1957</i>, that (I) (<del>were</del>) last saw the deceased alive on <i>Dec 17 1957</i>, and that death occurred at <i>10:05 p.m.</i> from the causes and on the date stated above.</p>				
23A. SIGNATURE <i>Charles W. Kerr</i>		23B. ADDRESS <i>6801 Belair Rd.</i>	23C. DATE SIGNED <i>Dec 20, 57.</i>	
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.				
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>12/20/57</i>	24C. NAME OF CEMETERY OR CREMATORIAL <i>Mt. View Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>Claremont, N.H.</i>
DATE RECEIVED BY <i>Local Registrar</i>		REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	25. FUNERAL DIRECTOR <i>Wm. J. Sickner &amp; Sons</i>	

BUREAU Y. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12785

## CERTIFICATE OF DEATH

12766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>12yr10mths2dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>3926 Norfolk Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Sarah</b>	Middle <b>Blumenthal</b>	Last <b>Friedman</b>	4. DATE OF DEATH	Month <b>December</b>	Day <b>13</b>	Year <b>1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>December, 1876</b>	9. AGE (In years last birthday) <b>81? yrs.</b>	10. IF UNDER 1 YEAR Months <b>81?</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Russia</b>	
13. FATHER'S NAME <b>Abraham Siegel</b>				14. MOTHER'S MAIDEN NAME <b>Naomi ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b>  DUE TO  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (c)  DUE TO							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 25, 1957</b> to <b>Dec. 13, 1957</b> , that I last saw the deceased alive on <b>Dec. 13, 1957</b> , and that death occurred at <b>6:45a M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Stella Wachsler</i>				ADDRESS (Street, city or town, state) <b>Cetonsville 28, Maryland</b> DATE SIGNED <b>12-13-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 13/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Chet Shalom</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md</b> Note	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Soldenison &amp; Butz Inc</i>		23c. ADDRESS <b>-1124-26 W. North Ave</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 16 '57</b>		24b. REG STAR'S SIGNATURE <i>W. L. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BONNEAU V. S.

DEC 19 1966

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BONNEAU

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be detached for use as the burial-trust permit. Then please remove carbon papers. Page 1 and 2 should be filed with the hospital or attending physician.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12786 CERTIFICATE OF DEATH

12767

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b>		c. LENGTH OF STAY IN lb <b>67 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Baltimore</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Old Court Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>ARTHUR</b>		First <b>M.</b>	Middle <b>.</b>	Last <b>FULLER</b>	4. DATE OF DEATH <b>December 31 1957</b>	Month <b>December</b>	Day <b>31</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1894</b>	9. AGE (In years from birthdate) <b>63 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Liquor</b>		11. BIRTHPLACE (State or foreign country) <b>Lauraville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George Fuller</b>			14. MOTHER'S MAIDEN NAME <b>Ida Barton</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 222-01-5104</b>		17. INFORMANT <b>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] <b>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG 163 X DUE TO Candidians, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</b>								
INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(County) (State)		
21. I certify that I attended the deceased from <b>October 25, 1957</b> , to <b>December 31, 1957</b> , and that death occurred at <b>457 M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)						
ACTUAL SIGNATURE <b>George Vash</b>		DATE SIGNED <b>12/31/57</b>						
PHYSICIAN'S NAME (Type) <b>GEORGE VASH, M. D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Sect. 17) <b>Burial</b>		22b. DATE THEREOF <b>Jan 3, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring D. Vash</b>		ADDRESS <b>5005 N. Highland Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>Dawson L. Shirley</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Shirley</b>		
DATE <b>1/4/58</b>		DATE <b>1/4/58</b>		DATE <b>1/4/58</b>		DATE <b>1/4/58</b>		

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12787 CERTIFICATE OF DEATH

12768

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>1607 Potomac Avenue</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1607 Potomac Avenue</b>		d. STREET ADDRESS <b>1607 Potomac avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Leslie</b>	First <b>Boyd</b>	Middle <b>Fuller</b>	Losi <b>December</b>	4 DATE OF DEATH <b>9th</b>	Month <b>1957</b>	Day <b>Year</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 25th 1894</b>	9. AGE (In years last birthday) <b>63 yrs.</b>	IF UNDER 1 YEAR <b>Months</b>	IF UNDER 24 HRS. <b>Days</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Glass Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Glass Industry</b>		11. BIRTHPLACE (State or foreign country) <b>Winchester Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Fuller</b>				14. MOTHER'S MAIDEN NAME <b>Emma Yew</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>216-05-7215</b>		17. INFORMANT <b>Mollie Fuller</b>		Address <b>1607 Potomac Avenue 27</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>Congestive Heart Failure</b> <b>Emphysema and</b> <b>Arteriosclerosis.</b>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Peptic Ulcer Active</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1305 Potomac Ave</b>	20f. (City or town) <b>Baltimore</b>	(County) <b>Baltimore</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>12/3/1952</b> to <b>12/8 1952</b> , that I last saw the deceased alive on <b>12/5/1952</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>J.N. Frederick</b> M.D. ADDRESS (Street, city or town, state) <b>1305 Potomac Ave</b> DATE SIGNED <b>12/10/52</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/52</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George A. Lubin Jr.</b>				ADDRESS <b>205 S. Ann St.</b>			
24a. REC'D BY REGISTRAR <b>12/10/52</b>				REGISTRAR'S SIGNATURE <b>M. Kelly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. Goss

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12718 CERTIFICATE OF DEATH

12784

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <b>Dundalk</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN TB 30 yrs		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b> Maryland</b>		b. COUNTY <b>Balto</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7021 5th Ave</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk, Md.</b>		d. STREET ADDRESS <b>7021 5th Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Peter</b>	Middle <b>Paul</b>	Last <b>Gabriel</b>	4. DATE OF DEATH Month <b>12</b> - Day <b>13</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>10-4-1903</b>	8. AGE (In years last birthday) <b>54 yrs.</b>	9. IF UNDER 1 YEAR Months <b>0</b>	10. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rethl, Steel Co</b>		11. BIRTHPLACE (State or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Gabriel</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give name or date of service)		17. INFORMANT <b>Agnes Gabriel</b>		Address <b>7021 5th Ave Dundalk</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>3508 BANK St</b>		20f. (City or town) <b>Balto</b>	(County) <b>Md.</b>
21. I certify that I attended the deceased from <b>Jan. 1957</b> , to <b>12/13 1957</b> , that I last saw the deceased alive on <b>12/13 1957</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>3508 BANK St</b>							
DATE SIGNED <b>12/13/57</b>							
ACTUAL SIGNATURE <i>Agnes R. Gabriele</i> M.D.							
PHYSICIAN'S NAME (Type) <b>SUSAN R. GABRIELE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral</b>		22b. DATE THEREOF <b>12-17-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Sacred Heart of Mary</b>		22d. LOCATION (City, town, or county) <b>Balto Md.</b>	
(State)							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Gabriele 1007 Dundalk Ave.</i>							
ADDRESS <b>1007 Dundalk Ave.</b>							
24a. RECD BY REGISTRAR DATE <b>12-18-57</b>							
24b. REGISTRAR'S SIGNATURE <i>John Kelly</i>							

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12770

## 12788 CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Washington</b>		c. LENGTH OF STAY IN 1b <b>Life</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6719 Broadview Road</b>		e. STREET ADDRESS <b>6719 Broadview Road</b>				
3. NAME OF DECEASED (Type or print) <b>George M.</b>		First <b>George</b>	Middle <b>M. Gambrill</b>			
		Last <b></b>	4. DATE OF DEATH <b>12</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
		8. DATE OF BIRTH <b>Nov. 25, 1879</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Steamfitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>			
		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>George Gambrill</b>		14. MOTHER'S MAIDEN NAME <b>Mary Brown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-10-0161</b>	17. INFORMANT Address <b>Calvin Gambrill 6719 Brodvier Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Hypertensive Cardio Vascular disease (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)				
20c. TIME OF INJURY Month, Day, Year Hour o. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) <b></b>	(County) <b></b>	(State) <b></b>
21. I certify that I attended the deceased from <b>Oct 1</b> , 1951, to <b>Dec 6</b> , 1957, that I last saw the deceased alive on <b>Dec 5</b> , 1957, and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above.						
ADDRESS (Street, city or town, state) <b>Harold H. Burns 115 E. Oager St. Baltimore 2 - Maryland</b>						
DATE SIGNED <b>Dec 5, 1957</b>						
ACTUAL SIGNATURE <b>Harold H. Burns</b>						
PHYSICIAN'S NAME (Type) <b>Harold H. Burns</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Butler Church Methodist Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gerald H. Seely 814 W 36th St.</b>		ADDRESS <b></b>		24a. REC'D. BY REGISTRAR DATE <b>DEC 10 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Newell</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THEAU V. S

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form BM3. Page 5 may be retained for records.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar for removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18								12771	
12789 MEDICAL EXAMINER'S CERTIFICATE OF DEATH								Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 16 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1099 West Fayette Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Georgia	Middle E.	Last Gilbert	4. DATE OF DEATH December 12 1957		Month Day Year		
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8, 1875		9. AGE (In years last birthday) 82 285 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) unknown	
13. FATHER'S NAME David Clark				14. MOTHER'S MAIDEN NAME Mary unknown				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO No Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cardiac failure</i> 904.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardio vascular disease</i> DUE TO (c) <i>fracture right forearm</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>accident</i>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Had been patient at Uncle Tom's Hosp., brought here 6 days ago</i>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Baltimore Md</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <b>George M. Kieffer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		DATE SIGNED <b>12-12-57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-16-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Peter's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>									
ADDRESS <b>William Cook, Inc., 1217 St. Paul Street</b>									
24a. REC'D BY REG STAR DATE <b>DEC 17 '57</b>									
24b. REGISTRAR'S SIGNATURE <b>John E. L.</b>									



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12790 CERTIFICATE OF DEATH**

12772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baynesville,</b>		c. LENGTH OF STAY IN 1b <b>Baynesville,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Baynesville,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1718 Yakona Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <b>Jane</b>	Middle <b>Edna</b>	Last <b>Glunt</b>	4. DATE OF DEATH <b>Dec. 20,</b>	Month <b>Dec.</b>	Day <b>20</b>	Year <b>19 57</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 25, 1882</b>		9. AGE (In years lost birthday) <b>75 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>McVeutown, Pa.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Charles E. Hinelsbaugh</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Rank</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>Mrs. Ethel G. Childs 6305 Charles St. Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>440.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Generalized arterio sclerosis</b> (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/15</b> , 19 <b>57</b> , to <b>12/20</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12/20</b> , 19 <b>57</b> , and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Gorden Grau</b> M.D. <b>8523 Loch Raven Blvd.</b> DATE SIGNED <b>12/21/57</b>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) <b>Gorden Grau, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 23, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mooreland Memorial Park</b>		22d. LOCATION (City, town, or county), (State) <b>Taylor Ave. Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>				ADDRESS <b>1900 Eutaw Pl. DE</b>			
24a. REC'D BY REGISTRAR <b>1957</b>				24b. REGISTRAR'S SIGNATURE <b>Dr. A. M. Bacar</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUDWISER

EG 2212



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12791

## CERTIFICATE OF DEATH

12773/4

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Fort Howard

c. LENGTH OF STAY IN 1b

36 days

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

3611

d. STREET ADDRESS

1107 Carson Ct.,

✓

• IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)First  
JOSEPHMiddle  
GOINS

Last

4. DATE  
OF  
DEATH

December 29

19 57

## 5. SEX

Male

## 6. COLOR OR RACE

Colored

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

7/26/88

9. AGE (In years  
less birthday)  
yrs.

69

## 10. IF UNDER 1 YEAR

Months

## 11. IF UNDER 24 HRS

Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Laborer

## 10b. KIND OF BUSINESS OR INDUSTRY

Cement Company

## 11. BIRTHPLACE (State or foreign country)

Virginia

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Albert Goins

## 14. MOTHER'S MAIDEN NAME

Betty West

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no unknown)  
(If yes, give war or dates of service)

Yes

WWI

## 16. SOCIAL SECURITY NO.

216-18-3864

## 17. INFORMANT

Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.

Address

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY.  
IMMEDIATE CAUSE (a)

BRONCHOGENIC CARCINOMA OF RIGHT BRONCHUS WITH

INTERVAL BETWEEN  
ONSET AND DEATH

162 X

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause first.

(b)

METASTASIS TO MEDIASTINAL LYMPH NODES

UNKNOWN

(c)

## PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. 19  
p. m.20d. INJURY OCCURRED  
While at work  Not while at work 

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

## 20f. (City or town)

## (County)

## (State)

## 21. I certify that I attended the deceased from November 23, 19 57 to December 29, 19 57 and that death occurred at 12:50 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

Chien Wei Lan

M.D. VAH Fort Howard, Maryland

12/30/57

PHYSICIAN'S  
NAME (Type)

CHIEN WEI LAN, M.D.

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

1-3-58

## 22c. NAME OF CEMETERY OR CREMATORIUM

Mount Olivet Cemetery

## 22d. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

Thomas E. Kelson Jr.

Presstman St., Balt.

Md.

## ADDRESS

1303

Presstman St., Balt.

Md.

## 24a. REC'D BY REGISTRAR

12/31/57

12/31/57

12/31/57

## 24b. REGISTRAR'S SIGNATURE

Thomas L. Harney

Thomas L. Harney

Thomas L. Harney

YOUNG

DEC 14 1957



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the Board of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Item 18 Film 223 1277437

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Off. No. 1277437

**12792**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2807 Laurel Wood Court</b>		d. STREET ADDRESS <b>2807 Laurel Wood Court</b>	
e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>JAMIE</b>	Middle <b>SUE</b>	Last <b>GOODMAN</b>
4. DATE OF DEATH	Month <b>December</b>	Day <b>1</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>June 24 1957</b>	9. AGE (In years from birthday) yrs. <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>
13. FATHER'S NAME <b>William L. Goodman</b>		14. MOTHER'S MAIDEN NAME <b>Alice Katzenstein</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>491X</b>	
17. INFORMANT <b>William L. Goodman - Son</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brunch pneumonia complicated by Aspiration of Vomitus</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Paul F. Querin</i>		DATE SIGNED <b>12/2/57</b>	
EXAMINER'S NAME (Type) <b>Paul F. Querin, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/2/57</b>	22c. NAME OF CEMETERY OR CEMATORIUM <b>Chesapeake</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sal Luriano &amp; Sons Inc.</i>		24a. REC'D BY REGISTRAR ADDRESS <b>1624-26 W. North St. Baltimore, Md.</b>	
		24b. REGISTRAR'S SIGNATURE <b>Dorothy Remley</b>	

BUREAU V. S.

50-1007

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FEB 19 1967

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12793

## CERTIFICATE OF DEATH

12775

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>89 Days</b>		b. COUNTY				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Louis</b>		First <b>NMI</b>	Middle <b>GOTTESMAN</b>	Last <b>December</b>	4. DATE OF DEATH Month <b>21</b> Day <b>19</b> Year <b>57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 21, 1894</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Scranton, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Ignatz Gottesman</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Simonowitz</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>216-03-8603</b>		17. INFORMANT <b>Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASTROCYTOMA, BRAIN</b>						INTERVAL BETWEEN ONSET AND DEATH <b>0 Months</b>		
1758 Conditions, if any, which gave rise to Immediate cause (a), stating the under- lying cause last. (b)		DUE TO						
{ DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Reading, Pa.</b>		(County) <b>Reading</b> (State) <b>Pa.</b>
21. I certify that I attended the deceased from Sept. 23, 1957, to Dec. 21, 1957, and that death occurred at 11:15 AM from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Maryland</b>		DATE SIGNED <b>12/21/57</b>
ACTUAL SIGNATURE <i>Silverie Q. Arce M.D.</i>								
PHYSICIAN'S NAME (Type) <b>Silverie Q. ARCE, M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>12/22/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Keshre-Zion</b>		22d. LOCATION (City, town, or county) <b>Reading, Pa.</b>		(State) <b>Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Selvin Levinson</i>		ADDRESS <b>1126 W. North Ave., Balt., Md.</b>		24a. REC'D. BY REGISTRAR DATE <b>12/22/57</b>		24b. REGISTRAR'S SIGNATURE <i>O. L. Farber</i>		

LEADER V. 8

FC C3 1957



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12794 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12776  
Reg. Dist. No.FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-travel permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>12794 MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>BALTIMORE</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>12794 Land Line</i>		c. LENGTH OF STAY IN TB <i>0</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8545 Pulaski Highway</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>12794 MARYLAND 21</i>	
f. STREET ADDRESS <i>8545 Pulaski Highway</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>EMMA E. 212 Abeth</i>	Middle <i>Gonland</i>	4. DATE OF DEATH <i>Dec. 22 1957</i>
5. SEX <i>F</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>MAY 6 1890</i>
9 AGE (In years less birthday) <i>67 yrs</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11 BIRTHPLACE (State or foreign country) <i>YORK, PA.</i>
12 CITIZEN OF WHAT COUNTRY? <i>American</i>	13. FATHER'S NAME <i>John B. Lantz</i>		
14. MOTHER'S MAIDEN NAME <i>ANNA Miller</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? Address (Yes, no, or unknown) <i>No</i> <i>340 N. North St., York, Pa.</i>		
16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT <i>Mrs. Dorothy R. Nyro</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crushing injury of chest</i> DUE TO <i>825X</i> Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (d)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <i>Automobile accident</i>		
20c. TIME OF INJURY Month, Day, Year <i>11:45 a.m. 12/22 1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>RT. 111</i>	20f. CITY OR TOWN (County) (State) <i>1/4 mile from RT. 111, York, Pa.</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>R. M. France</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <i>R. M. France</i>	DATE SIGNED <i>12/22/57</i>		
22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>13 LF 10A</i>	22b. DATE THEREOF <i>12/26/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Green Mount Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>York, Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Towson Inc - Towson MD</i>	24a. REC'D BY REGISTRAR <i>12/26/57</i>	24b. REGISTRAR'S SIGNATURE <i>Chester Fulton</i>	

PHILADELPHIA V.

DEC 11 1951

125-122  
125-122

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Reg. Dist. No. 127745

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12795 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institutional Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b <b>6 mo</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		d. STREET ADDRESS <b>LANGLEY RD</b>			
d. NAME OF HOSPITAL <b>HOSPITAL</b>		e. ADDRESS (If not in Hospital, give street address) <b>409 LANGLEY RD</b>		f. STREET ADDRESS <b>409 Edgewater Apts.</b>		g. SCHEDULED ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>RAYMOND</b>	Middle <b>HOWARD</b>	Last <b>GRAHAM</b>	4. DATE OF DEATH	Month <b>December</b>	Day <b>17,</b>	Year <b>1957</b>		
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	DATE OF BIRTH <b>JUNE 2, 1957</b>	9. AGE (in years last birthday) <b>6 yrs</b>	10. IF UNDER 1 YEAR Months <b>6</b>	11. IF UNDER 24 HRS Days <b>15</b>	12. IF UNDER 24 HRS Hours <b>00</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>BOBBY J. GRAHAM</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA HEDDAK</b>		Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>B. J. GRAHAM</b>		INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Interstitial Pneumonia</b>									
492X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____									
DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>William V. Lovitt</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>12/17/57</b>				
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/20/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National Mort. Md.</b>		22d. LOCATION (City, town, or county) (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Funeral, Md.</b>	ADDRESS <b>1033 E. 21st St. X v.</b>		24a. REC'D BY REGISTRAR <b>DEC 13 1957</b>		24b. REC'D BY STRAHL'S SIGNATURE <b>Edith Strahl</b>				

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12796 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<b>BALTIMORE</b>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY	
		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<b>846 OAKLEIGH BEACH AVE.</b>		<b>846 OAKLEIGH BEACH AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<b>ELEANORA</b>		<b>F</b>	<b>GRANVILLE</b>
4. DATE OF DEATH	Month	Day	Year
	<b>12</b>	<b>11</b>	<b>1957</b>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<b>F</b>	<b>W</b>		<b>NOV. 14 1904</b>
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
<b>53</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<b>MIXER = Poplar Club BEV. Co.</b>		<b>= BALTO - MD.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<b>NOT KNOWN</b>		<b>NOT KNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)			
17. INFORMANT		Address	
<b>GEO C. JR.</b>		<b>846 OAKLEIGH BEACH Ave.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		
<b>420.1</b>		<b>Coronary Occlusion</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
(b) <b>Hypertensive Cardio-Vascular Disease</b>		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
	<b>gunshot</b>					
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour a. m. p. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				
	<b>19</b>					

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
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ACTUAL SIGNATURE	<b>M B Davis MD</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type)	<b>M B. Davis MD</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	<b>17/13/57</b>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)
<b>CREMATION</b>	<b>12/14/57</b>	<b>GREENMOUNT CEMT.</b>	<b>BALTO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<b>L. F. Hoffmann</b>	<b>3218 Hudson St.</b>	<b>10/17/57</b>	<b>Edith Murphy M. Baker</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar.

or retain.



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12797

Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37

12779  
37

Reg. Dist. No.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison Xo						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrison, Maryland		d. STREET ADDRESS Surmont						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) SIDNEY		First	Middle					
Last		4. DATE OF DEATH	Month					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Year
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 31, 1887				1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Retired		Self		Baltimore, Maryland		U.S.A.		
13. FATHER'S NAME Daniel Greenbaum		14. MOTHER'S MAIDEN NAME Frances ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-07-0255		17. INFORMANT Mr. Daniel S. Greenbaum-Garrison, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Metastases to Bladder		INTERVAL BETWEEN ONSET AND DEATH 6 mos				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) DUE TO Cancer of rectum		2 yrs				
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____ 6/8 _____, 1957, to _____ 12/2 _____, 1957, that I last saw the deceased alive on _____ Nov 27, 1957, and that death occurred at _____ 8:00 A.M. from the causes and on the date stated above. ACTUAL _____ Dr. Jonas H. Cohen MD						ADDRESS (Street, city or town, state) DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/57		22c. NAME OF CEMETERY OR CREMATORIUM Balto. Hebrew Congre. Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons		ADDRESS 1000 Pa. Ave.		24a. REC'D BY REGISTRAR DATE 12/3/57		24b. REGISTRAR'S SIGNATURE Dorothy Revell		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 1 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BESTIAL V. S

DEC A 1977



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12798 CERTIFICATE OF DEATH

12789

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Parkland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea Rural</b>		c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea Rural</b>		d. STREET ADDRESS <b>7415 Kenlea Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7415 Kenlea Avenue</b>				d. STREET ADDRESS <b>7415 Kenlea Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Karl Konrad Hacke</b>		First	Middle	Last	4. DATE OF DEATH Month <b>12</b>	Day <b>13</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>3/12/1904</b>	9. AGE (In years lost birthday) yrs. <b>53</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Motors</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hacke</b>				14. MOTHER'S MAIDEN NAME <b>Kunigunda Hopfengartner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-01-3369</b>		17. INFORMANT <b>Mrs. Dorothy E. Hacke</b>		Address <b>7415 Kenlea Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				<b>Metastatic carcinoma rectum ca</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1 W. OVERLEA AVE</b>		20f. (City or town) (County) (State) <b>Baltimore</b>	
21. I certify that I attended the deceased from <b>July 19</b> to <b>Dec 13</b> , 1957, that I last saw the deceased alive on <b>Dec 12</b> , 1957, and that death occurred at <b>PP</b> M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>1 W. OVERLEA AVE</b>		DATE SIGNED <b>1957</b>	
ACTUAL SIGNATURE <b>D. G. LEED, D.D.B., BALTO, MD</b>							
PHYSICIAN'S NAME (Type) <b>D. G. LEED, D.D.B., BALTO, MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/17/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Parkwood</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lawson Funeral Home</b>		ADDRESS <b>7401 Belair Rd</b>		24a. REC'D BY REGISTRAR <b>191957</b>		24b. REGISTRAR'S SIGNATURE <b>Miss L. Rutherford</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Log in by the funeral director.  
 To be retained by the hospital or attending physician.  
 To be detached for use as the burial-tranit permit. Then please remove carbon papers. Page 2 should be filed with the record prior to burial, cremation, or removal, and in any event within 72 hours after death.

PEPPARD V. S.

DEC 9 1957

PEPPARD V. S.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12799 CERTIFICATE OF DEATH**

12781/4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Baltimore X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1050 Old North Point Road		d. STREET ADDRESS 1050 Old North Point Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM		First DEVIN	Middle HACKETT
4. DATE OF DEATH Month December Day 10 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH August 10, 1914
8. AGE (in years, last birthday) 43 yrs.		9. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	10. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY Western Electric Co. Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Edwin M. Hackett		14. MOTHER'S MAIDEN NAME Louisa Hilmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. Mrs. Margaret Hackett 1050 Old North Point Road	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 10 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Chronic Glomerular Nephritis 10 years	
(b) DUE TO		Hyper tension 15 years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1942 to Dec 10, 1957, that I last saw the deceased alive on Dec 10, 1957, and that death occurred at 3:20 P.M. from the causes and on the date stated above.			
ACTUAL TURE PHYSICIAN'S NAME (Type) Morris A. Jacobs		ADDRESS (Street, city or town, state) 1010 NORTH Point Rd DATE SIGNED 12/11/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 13, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery
22d. LOCATION (City, town, or county) Colgate, Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road,		24a. REC'D BY REGISTRAR DEPT. 12/11/57	24b. REGISTRAR'S SIGNATURE Lawson H. Kelly

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the record prior to burial, cremation, or removal, and in any event within 72 hours after death.

REV  
201

8 A.D.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12782

12800

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c LENGTH OF STAY IN Tb		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		d. STREET ADDRESS 4 Dutton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Katherine		First	Middle	Last	4. DATE OF DEATH Dec. 23 1957	Month	Day Year
5. SEX F	6. COLOR OR RACE V	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> April 29, 1880	9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William S. Enis		14. MOTHER'S MAIDEN NAME Am. S. Shirley LEPSON		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO --		17. INFORMANT Mrs. Henry H. Helfrich 4 Dutton Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost		Carcinoma of Jaw		2 mos -			
(b) DUE TO		Broncho pneumonia		3 days			
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension 4 yrs						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 23, 1957, that I last saw the deceased alive on Dec 23, 1957, and that death occurred at 8:30 AM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE John Moore Fort		M.D.		1118 St. Paul St. Balt. 2			
PHYSICIAN'S NAME (Type) Wetherbee Fort				1118 St. Paul St.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-57		22c. NAME OF CEMETERY OR CREMATORIUM Western Gem.		22d. LOCATION (City, town, or county) Baltimore Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 30 '57		24b. REGISTRAR'S SIGNATURE John Moore	

BAUER Y.

DEC 1965

REGELIVE

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1  
FOR STATE  
DEPT.  
AL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in my opinion death resulted from natural causes.

V.S. A15ME  
SM 2/57



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12801 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		RURAL - Millers		c. LENGTH OF STAY IN lb		a. STATE Maryland b. COUNTY Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Millers		
e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	9. AGE (In years, months, days)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS		
m		w	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> NV 3. 1903	64 yrs	Months Days	Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done, giving most recent working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Chamber-of-Commerce		Private Family		Maryland		USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
William Harris		Florence Schaefer						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No				Mrs. Chas. L. Harris - Millers, Md,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a), stating the underlying cause lost.		Coronary occlusion						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) DUE TO						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE		A. M. France		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/5/57		
EXAMINER'S NAME (Type)		A. M. France						
22a. BURIAL CREMATION REMOVAL (Type if)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)		
BURIAL DEC. 7, 1957				Prospect Hill Cem.		Towson, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
John Burns' Sons - Towson, Md.				DEC 9 '57		K. Lewis		

May 8

REGGIE

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12802

## CERTIFICATE OF DEATH

1278438

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE  Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Riderwood	c. LENGTH OF STAY IN 1b  Life	b. COUNTY  Baltimore, Md.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Riderwood X
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  1515 Joppa Road		d. STREET ADDRESS  1515 Joppa Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First  Robert Alexander Taylor Harrison	Middle  Harrison	Last  Dec. 16, 1957
4. DATE OF DEATH	Month Dec.	Day 16,	Year 1957
5. SEX  Male	6. COLOR OR RACE  White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH  April 12, 1903
9. AGE (In years from birth) 54 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Retired - Hotel	10b. KIND OF BUSINESS OR INDUSTRY  2 m 2 r	11. BIRTHPLACE (State or foreign country)  Maryland	12. CITIZEN OF WHAT COUNTRY?  U.S.A.
13. FATHER'S NAME  Frank Tudor Harrison	14. MOTHER'S MAIDEN NAME  Charlotte F. Taylor		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  No	16. SOCIAL SECURITY NO.  (If yes, give war or dates of service)	17. INFORMANT  D. Heyward Hamilton, Jr. Ruxton 4, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		INTERVAL BETWEEN ONSET AND DEATH  0 ESOPHAGEL HEMMORRHAGE 2-3 WEEKS	
(b) DUE TO  ALCOHOLIC CIRRHOSIS OF LIVER 1 YEAR		(c) WITH ASCITES AND MALNUTRITION 10 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  20f. (City or town)  (County)  (State)
21. I certify that I attended the deceased from DEC 16, 1956, to DEC 16, 1957, that I last saw the deceased alive on DEC 16, 1957, and that death occurred at 3 PM, from the causes and on the date stated above.  ADDRESS (Street, city or town, state)  DATE SIGNED			
ACTUAL SIGNATURE  Ralph G. Hills	M.D.	18 E. EAGER ST. BALTO. 2 MARYLAND	
PHYSICIAN'S NAME (Type)  Dr. Ralph G. Hills	18 E. Eager St. Baltimore 2, Md. Dec 17 '57		
22a. BURIAL, CREMATION, REMOVAL (Specify)  Buried Dec 18 1957	22b. DATE THEREOF  Dec 18 1957	22c. NAME OF CEMETERY OR Crematory  Loudon Park	22d. LOCATION (City, town, or county)  Baetoy Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE  Henry W. Jenkins 4905 York Rd.	ADDRESS	24a. RECD. BY REGISTRAR DATE DEC 15	24b. REGISTRAR'S SIGNATURE  Mabel Gray

GUERRA Y.

200 200

1900 1900

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12803

## CERTIFICATE OF DEATH

12785 32  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>WEST OCEAN CITY MD.</b>		b. COUNTY <b>WICHEE M.D.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN lb <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WEST OCEAN CITY MD.</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	<b>HASTINGS</b>	Middle <b>HARRY</b>	Last <b>WILLIAM</b>	4. DATE OF DEATH <b>12</b>	Month <b>1</b>	Day <b>1957</b>	Year
5. SEX <b>M</b>	6. COLOR OF RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/15/10</b>	9. AGE (in years lost birthday) <b>47 yrs.</b>	10. IF UNDER 1 YEAR Months <b>10</b>	11. IF UNDER 24 HRS Days <b>15</b>	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FISHERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>HASTINGS, LAMBERT</b>		14. MOTHER'S MAIDEN NAME <b>SARA FISHER</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>WWII ARMY</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		<b>CARCINOMA OF THE LUNG</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baltimore</b>	(County) <b>Md.</b>	(State)	
21. I certify that I attended the deceased from <b>11/26/1957</b> to <b>12/11/1957</b> , that I last saw the deceased alive on <b>11/30/1957</b> , and that death occurred at <b>8:45 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b> DATE SIGNED <b>William Newcomer</b>							
ACTUAL SIGNATURE <b>William Newcomer</b> M. D., Superintendent							
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>		22b. DATE THEREOF <b>12/3/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>CYPRESS CREEK</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Doris A. Bubby</b>		ADDRESS <b>Baltimore, Md.</b>		24. DECD BY REGISTRAR DATE <b>DEC 4 1957</b>		25. REGISTRAR'S SIGNATURE <b>Dorothy Penley</b>	

BUREAU V. S

DEC 4 1951

REGELVAD

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12719

## CERTIFICATE OF DEATH

12786

41

Reg. Dist. No.

## 1. PLACE OF DEATH

o. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Dundalk

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

---

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Md

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Dundalk

d. STREET ADDRESS

11901 Walnut Ave

e. IS RESIDENCE ON A FARM?

YES  NO 3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

1888

Oct 14 1888

9. AGE (In years lost birthday)

69 yrs.

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

11. IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY

al home

Cyrus Shanks

U. S.

13. FATHER'S NAME

Don't Know

14. MOTHER'S MAIDEN NAME

Don't Know

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, No, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Vincent Hauk 4432 O'Donnell

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which

gave rise to immediate

cause (a), stating the under-

lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

5 min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Diabetes Mellitus

19. WAS AUTOPSY PERFORMED?

YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. 19  
p. m.20d. INJURY OCCURRED  
While Not while  
at work  at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-20 1957 to 12-20 1957 that I last saw the deceased alive on 12-16 1957, and that death occurred at 12:45 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

Jack Collins M.D. 2 hours ago

PHYSICIAN'S NAME (Type)

Jack Collins BALTIMORE Md

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial See 24. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

DATE 24. REGISTRAR'S SIGNATURE

24b. REGISTRAR'S SIGNATURE

John Kelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

GUINEAU V. S.

CC - 1960

REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12787

## 12720 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN lb <b>18 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk 22</b>		d. STREET ADDRESS <b>2903 Dunglow Road</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2903 Dunglow Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>CHARLES</b>	Middle <b>MATTHEW</b>	Last <b>HELMAN, Sr.</b>	4. DATE OF DEATH <b>December 5th, 1957</b>	Month Day Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 4, 1903</b>	9. AGE (In years lost birthday) <b>54 yrs</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Locomotive Eng.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY <b>USA.</b>		
13. FATHER'S NAME <b>John Helman</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Blough</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>190-05-4498</b>		17. INFORMANT <b>Elizabeth L. Helman</b>		Address <b>as in #2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Generalized Cirrhosis</i>				INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		<i>Cirrosis of Liver</i>				1-2 yrs?		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>	(County) <b>Baltimore Co.</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Sept. 1, 1957</b> , to <b>Dec. 5, 1957</b> , that I last saw the deceased alive on <b>Dec. 5, 1957</b> , and that death occurred at <b>6:40 PM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>James T. Means, 4th &amp; D Sts., Sparrows Point 19, Maryland</b>		
SIGNATURE <i>James T. Means</i>		M.D.				DATE SIGNED <b>12/7/57</b>		
PHYSICIAN'S NAME (TYPE) <b>James T. Means, M.D., 4th &amp; D Sts., Sparrows Point 19, Maryland</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore Co., Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Brasher Bradley</i>		ADDRESS <b>Dundalk 22, Md.</b>		24a. REC'D. BY REGISTRAR <b>DEC 9 1957</b>		24b. REGISTRAR'S SIGNATURE <i>Mr. Kelly</i>		

W. S.

100  
100

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12804 CERTIFICATE OF DEATH

12788

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>5yr6mth10dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>3507 Walbrook Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Martha</b>		First	Middle	Last	4. DATE OF DEATH <b>DECEMBER 4</b>	Month	Day	Year <b>1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Dec. 5, 1871</b>	9. AGE (In years lost birthday) <b>05 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Henry Hepperla</b>		14. MOTHER'S MAIDEN NAME <b>Mary Louise Coale</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STAT: HOSPITAL</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>400.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		<b>ARTERIOSCLEROTIC HEART DISEASE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 YRS. +</b>		
		<b>GENERALIZED ARTERIOSCLEROSIS</b>				" " "		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from <b>Oct. 18</b> , 19 <b>57</b> , to <b>Dec. 4</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec. 3</b> , 19 <b>57</b> , and that death occurred at <b>2:14 P.M.</b> from the causes and on the date stated above		ADDRESS (Street, city or town, state)						DATE SIGNED
ACTUAL SIGNATURE <i>Jonas R. Rapaport</i>	M.D. SPRING GROVE STATE HOSPITAL							
PHYSICIAN'S NAME (Type) <b>Jonas R. Rapaport M.D.</b>	Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/5/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) <b>Balto. Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Nickner &amp; Sons - Balt. Md.</i>	ADDRESS <b>1414 N. Charles St. Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>Dec. 5, 1957</b>		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>			

PELLEW V. S

DEC

12/25/84

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12805 CERTIFICATE OF DEATH

Reg. Dkt. No. 12789 45

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b RURAL and give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7009 Dunbar Road		d. STREET ADDRESS 7009 Dunbar Road #22	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle EDWARD	Last Hertje
4. DATE OF DEATH	Month 12	Day 1	Year 1957
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1860
9. AGE (In years from birth) 97 yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pomeroy, Ohio
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Valentine Hertje	14. MOTHER'S MAIDEN NAME Barbara Huff		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Ida Clark-7009 Dunbar Road-Balto. 22, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		ARTERIOSCLEROTIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
(b) DUE TO Generalized Arterio Sclerosis		20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <u>105 Jan.</u> , 1955, to <u>12-1</u> , 1957, that I last saw the deceased alive on <u>12-1</u> , 1957, and that death occurred at <u>1035</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type) JACK C COLLINS	M.D.	ADDRESS (Street, city or town, state) 2 Kinship BALT 22	DATE SIGNED 12-1-57
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/4/57	22c. NAME OF CEMETERY OR CREMATORIUM Hertje Cemetery	22d. LOCATION (City, town, or county) (State) Jackson County, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker & Son & Daughters	ADDRESS	24a. REC'D BY REGISTRAR DATE 12/3/57	24b. REGISTRAR'S SIGNATURE Edith Turley

SUREAU V.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12806 CERTIFICATE OF DEATH

12790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN 1b <b>1 day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3101 11
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>124 Osburn Road</b>		d. STREET ADDRESS <b>2017 E. 32nd St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Grace R. Hildreth</b>	First <b>Grace</b>	Middle <b>R.</b>	Last <b>Hildreth</b>	4. DATE OF DEATH <b>12/26/57</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/17/1922</b>	9. AGE (In years less birthday) <b>35</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Liquor Board</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Office</b>		10c. BIRTHPLACE (State or foreign country) <b>Baltimore</b>
13. FATHER'S NAME <b>Clarence Hildreth</b>		14. MOTHER'S MAIDEN NAME <b>M. Cornelia Hildreth</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>Clarence Hildreth 2017 E. 32nd. St.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <i>Cerebral Thrombosis</i> <span style="float: right;">IMMEDIATE</span> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)  <i>Rheumatic Heart Disease</i> <span style="float: right;">Focal</span> DUE TO  Underlying cause (c)  <i>Hypertension, Myocarditis</i> <span style="float: right;">"</span>				
INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>19</b>	Day	Year	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>1403 Park Ave</b>		(County) <b>Baltimore</b>	(State) <b>MD</b>
21. I certify that I attended the deceased from <b>Oct</b> , 19 <b>40</b> , to <b>Dec 26, 1952</b> , that I last saw the deceased alive on <b>Aug 24, 1952</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above.				
ADDRESS (Street, city or town, state) <b>1403 Park Ave</b>				
DATE SIGNED <b>12/26/57</b>				
ACTUAL SIGNATURE <b>M. J. Hoadley</b>				
PHYSICIAN'S NAME (Type) <b>M. J. Hoadley</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-30-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	(State) <b>MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd.</b>	24a. REC'D BY REGISTRAR <b>12/26/57</b>	24b. REGISTRAR'S SIGNATURE <b>John T. Stansbury</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-travel permit. Then please remove carbon papers. Page 2 should be filed with the records of the funeral home or prior to burial, cremation, or removal.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12791

34

**Reg. Dist. No.**

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Baltimore				b. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Baltimore	
Rural - Free Land		23 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Ridge Rd.		Ridge Rd.			
3. NAME OF DECEASED (Type or print)	First Daniel	Middle W.	Last Hikker	4. DATE OF DEATH	Month Dec. Day 20 Year 1957
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1864	9. AGE (In years at birthday) 93 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.	
Laborer				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Hikker.		14. MOTHER'S MAIDEN NAME Sarah Zimmerman		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT Mrs. Cora Hikker, Free Land, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Cerebro-vascular accident.		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Hypertension		18 hours.	
DUE TO (c) Unknown					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) marked obesity					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cerebral thrombosis - no injury			
20c TIME OF INJURY Hour o.m. p.m.	Month. 19	Doy. Not while at work <input type="checkbox"/>	Year of work <input type="checkbox"/>	20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20e. (City or town) (County) (State)
21. I certify that I attended the deceased from 9 - 4 - 1955 to 12 - 19 - 1957, that I last saw the deceased alive on 12 - 19 - 1957, and that death occurred at 10:30 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE	R. Robinson,	M.D.	ADDRESS (Street, city or town, state)		DATE SIGNED 12-23-57
PHYSICIAN'S NAME (Type)	R. ROBINSON				

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Page 2 should be filed with the records prior to burial, cremation or removal and in any event within 72 hours after death.

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БОРДАУ В. С.

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СОГЕИВЕО

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12792

12808

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1807 E. Joppa Road</i>				d. STREET ADDRESS <i>1807 E. Joppa Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mr. John M. Hilliard</i>		First <i>John</i>	Middle <i>M.</i>	Last <i>Hilliard</i>	Sr.	4. DATE OF DEATH <i>December 17th 1957</i>	Month Year		
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 15, 1890</i>		9. AGE (In years last birthday) <i>57 yrs.</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY/ <i>USA</i>			
13. FATHER'S NAME <i>John M. Hilliard</i>		14. MOTHER'S MAIDEN NAME <i>Wilhelmina</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Ret. no. or unknown)		16. SOCIAL SECURITY NO. <i>213-10-7242</i>		17. INFORMANT <i>Mrs. Anna Marie Hilliard,</i>		Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH <i>March 1957</i>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>18</i>		DUE TO <i>Metastatic Carcinoma</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO <i>Epidemoid Carcinoma</i>							
(c) DUE TO <i>probably lung</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Park</i>		20f. (City or town) <i>Baltimore, Maryland</i>		(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>March 1957</i> , to <i>December 11, 1957</i> , that I last saw the deceased alive on <i>December 11, 1957</i> , and that death occurred at <i>9 AM</i> , from the causes and on the date stated above						ADDRESS (Street, city or town, state) <i>700 N Charles St</i>		DATE SIGNED	
ACTUAL SIGNATURE <i>William L. Garlick</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>William L. Garlick, M.D.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/14/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Moreland Mem. Park</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>REC 1710</i>		24b. REGISTRAR'S SIGNATURE <i>Mabel Grace</i>			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12793

Reg. Dist. No.

## 12809 CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Sparrows Point, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 432 "F" Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Sebastian	Middle	Last Hock
4. DATE OF DEATH	Month 12	Day 17	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1882
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Adam Hock		14. MOTHER'S MAIDEN NAME Maggie Schindhelm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 605X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Ruptured bladder DUE TO (c) Acute urinary retention and cystitis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 20, 1957, to Dec. 17, 1957, that I last saw the deceased alive on Dec. 17, 1957, and that death occurred at 12 P. M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Stella Wachsler</i>	M.D. SPRING GROVE STATE HOSPITAL 12-18-57.		
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.	Catonsville 28, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-21-57.	22c. NAME OF CEMETERY OR CREMATORIUM SACRED HEART CEM.	22d. LOCATION (City, town, or county) GERMAN HILL RD., M.D.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeller	ADDRESS 901 S. CONKLING ST. BALTO., MD.	24a. REC'D BY REGISTRAR DATE DEC 2 3 '57	24b. REG STRR'S SIGNATURE <i>Albert Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12810

## CERTIFICATE OF DEATH

1279431  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Holbrook</i>	c. LENGTH OF STAY IN 1b <i>Life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Holbrook</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>	d. STREET ADDRESS <i>Marriottsville P.O. Md.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Sarah</i>	First <i>Sarah</i>	Middle <i>Va</i>	Last <i>Horn</i>		
4. DATE OF DEATH <i>Dec. 11, 1957</i>	Month <i>Dec.</i>	Day <i>11</i>	Year <i>1957</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 3, 1868</i>		
9. AGE (In years last birthday) <i>89 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Spouse wife own home</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>Md.</i>		
13. FATHER'S NAME <i>Jesse Dell</i>	14. MOTHER'S MAIDEN NAME <i>Susanna Parker</i>	Address <i>Marriottsville, Maryland</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>None</i>	17. INFORMANT <i>Marieetta Parker, Marriottsville, Md.</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest, Cardiac failure</i> DUE TO <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) <i>arteriosclerosis, hypertension, left hemiplegia</i> DUE TO (c) <i>Carcinoma of breast i metastasis</i>	INTERVAL BETWEEN ONSET AND DEATH <i>1957</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>None</i>	(County) <i>None</i>	(State) <i>None</i>
21. I certify that I attended the deceased from <i>Aug.</i> , 1957, to <i>Dec. 11, 1957</i> , that I last saw the deceased alive on <i>10 Dec.</i> , 1957, and that death occurred at <i>3:00 A.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Howard E. Hail</i>	ADDRESS (Street, city or town, state) <i>Almonville, Md.</i>			DATE SIGNED <i>11 Dec. 57</i>	
PHYSICIAN'S NAME (Type) <i>HOWARD E. HAIL</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Wards Chapel</i>			22d. LOCATION (City, town, or county) <i>Holbrook, Bell Co., Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-14-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Wards Chapel</i>		22d. LOCATION (City, town, or county) <i>Holbrook, Bell Co., Md.</i>	
23. FUNERAL-DIRECTOR'S SIGNATURE <i>Arthur H. Height</i>	ADDRESS <i>Almonville, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>12-13-57</i>		24b. REGISTRAR'S SIGNATURE <i>C. Wesley J. Martin</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12811 CERTIFICATE OF DEATH

12795 33  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>		c. LENGTH OF STAY IN 16 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
3. NAME OF DECEASED (Type or print)		First <b>WILLIAM</b>	Middle <b>KINDLE</b>	Last <b>HOWE</b>	4. DATE OF DEATH 12 18 1957
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10.10.03</b>	9. AGE (In years last birthday) <b>54 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>JOHN HOWE</b>		14. MOTHER'S MAIDEN NAME <b>EMMA MC BRIDE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ODAX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c)		Tuberculous meningitis pulmonary tuberculosis INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>4 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>LATE LATENT SYPHILIS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) —			
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day 19	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 26, 1957</b> , to <b>December 19, 1957</b> , that I last saw the deceased alive on <b>12 - 19</b> , 1957, and that death occurred at <b>10:15 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <i>William Newcomer</i>		M.D. <b>Mt. Wilson, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 24, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Peters</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b> (State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc.</b>		ADDRESS <b>1217 St. Paul St.</b>	24a. REC'D BY REGISTRAR <b>DEC 24 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Lee</b>

BUREAU V. S

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W. M. V.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12812

## CERTIFICATE OF DEATH

12796  
44

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>11 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FEDERAISBURG</b>	
3. NAME OF DECEASED (Type or print) <b>LeROY</b>		First <b>J</b>	Middle <b>HULLIGER, SR.</b>
4. DATE OF DEATH <b>DECEMBER 22 1957</b>	Month <b>Month</b>	Day <b>Day</b>	Year <b>Year</b>
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-16</b>
9. AGE (In years lost birthday) <b>41 yrs</b>	10. IF UNDER 1 YEAR Months <b>11 months</b>	11. IF UNDER 24 HRS. Days <b>22 days</b>	12. IF UNDER 24 HRS. Hours <b>19 hours</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11. BIRTHPLACE (State or foreign country) <b>PRESTON, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN L HULLIGER</b>		14. MOTHER'S MAIDEN NAME <b>ANNA KNOX</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>578-01-5210</b>	
(If yes, give war or dates of service) <b>WW-II</b>		17. INFORMANT <b>VET. ADM. HOSP., CLIN. RECORDS, FT HOWARD MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RHEUMATIC CARDIOVASCULAR DISEASE, AORTIC STENOSIS</b> <b>4/11 X</b> <b>EXSTOX AND INSUFFICIENCY</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 11, 1957, to December 22, 1957</b> , and that death occurred at <b>12:35 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Irving Freeman</i>		ADDRESS (Street, city or town, state) <b>M.D. VAH, FORT HOWARD, MARYLAND</b>	
DATE SIGNED <b>12/23/57</b>			
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>		22d. LOCATION (City, town, or county) (State) <b>FEDERAISBURG, MARYLAND</b>	
22e. BURIAL, CREMAT. ON, REMOVAL (Specify) <b>Burial</b>		22f. DATE THEREOF <b>Dec. 26, 1957</b>	
22g. NAME OF CEMETERY OR CREMATORIUM <b>HILL CREST CEMETERY</b>		22h. REGISTRAR'S SIGNATURE <i>Dawson L. Farley</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Frampton &amp; Son, Federalsburg, Maryland</i>		24a. REC'D BY REGISTRAR DATE <b>DEC 26</b>	
VS AIS (4) 15M 9/55		24b. REGISTRAR'S SIGNATURE	

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DEC 7 1968

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12797

## 12725 CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Arbutus 27					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3900 Annapolis Road				d. STREET ADDRESS 3900 Annapolis Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ida		First	Middle M.	Last Hyson	4. DATE OF DEATH December	Month 11	Day 19	Year 57	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 25, 1878	9. AGE (In years last birthday) 79	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Franklin W. Ascheneier, Jr., 3900 Annapolis Road		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4451 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last (b) DUE TO (c) <i>Cerebral Vascular Accident</i> 2 weeks							INTERVAL BETWEEN ONSET AND DEATH 5 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10		20f. (City or town) Baltimore		(County)	(State)
21. I certify that I attended the deceased from <i>Dec 5</i> , 1957, to <i>Dec 11</i> , 1957, that I last saw the deceased alive on <i>Dec 5</i> , 1957, and that death occurred at <i>10</i> M. from the causes and on the date stated above.							ADDRESS (Street, city or town, state) <i>236 Annapolis Rd.</i>		
ACTUAL SIGNATURE <i>Paul Schenfeld</i>		PHYSICIAN'S NAME (Type) <i>Paul Schenfeld</i>		DATE SIGNED <i>12-14-57</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-14-57		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery		22d. LOCATION (City, town, or county) Baltimore			(State)
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>DEC 17 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. G. M. Tupper</i>			

BUREAU V. S

DEC 11 1968



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12813

## CERTIFICATE OF DEATH

12798 45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bauernschmidt Manor	c. LENGTH OF STAY IN 1b 2 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bauernschmidt Manor-Balto. 20, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS Route 1, Box 727,		
3. NAME OF DECEASED (Type or print)	First VACLAV	Middle JOSEPH	Last JANATA
4. DATE OF DEATH December 4 1957	Month Day Year		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Mar. 16, 1879
8. AGE (In years last birthday) 78 yrs.		9. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. Hardware		10b. KIND OF BUSINESS OR INDUSTRY Own Business	11. BIRTHPLACE (State or foreign country) Czechoslovakia
13. FATHER'S NAME Anton Janata		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	17. INFORMANT Amelia Kotras, dght, above
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day  Arterio-sclerotic Heart Disease 6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dobar Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	DATE SIGNED
19			
21. I certify that I attended the deceased from Feb. 1955 to Dec 4 1957 that I last saw the deceased alive on Dec 4 1957, and that death occurred at 5:45 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Miceli, M.D.	ADDRESS (Street, city or town, state) 108 S. TAYLOR AVE BALTIMORE, MD. 21205		
PHYSICIAN'S NAME (Type) Joseph Miceli, M.D.	DATE SIGNED 12/16/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/7/57	22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery	22d. LOCATION (City, town, or county) Baltimore, Md. (State)
22e. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home 3331 Brehms Lane	ADDRESS 3331 Brehms Lane	24e. REG'D BY REGISTRAR 12/7/57	24f. REGISTRAR'S SIGNATURE Edith Shirley

دیگر از اینجا  
میخواستم بخواهم

که اینجا کجا

که اینجا کجا

که اینجا کجا

که اینجا کجا

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12814

## CERTIFICATE OF DEATH

12799

Reg. Dist. No. 43

1. PLACE OF DEATH a. COUNTY <i>BALTO.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD.</i>		b. COUNTY <i>BALTO.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>OVERLEA</i>		c. LENGTH OF STAY IN 1b <i>LIFE</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>OVERLEA</i>		d. STREET ADDRESS <i>7305 LINDEN AVE</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7305 LINDEN AVE</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Clara</i>	Middle <i>V. GRIFFIN</i>	Last <i>Johnson</i>	4. DATE OF DEATH <i>DEC. 7, 1888</i>	Month <i>12</i>	Day <i>16</i>	Year <i>1957</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC. 7, 1888</i>	9. AGE (In years last birthday) <i>69</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm. GRIFFIN</i>		14. MOTHER'S MAIDEN NAME <i>HARRIET Hamilton</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Elizabeth Bartz - 2009 N. Fulton Ave</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>		DUE TO <i>hypertensive cerebral disease</i>		DUE TO <i>hypertensive cerebral disease</i>		DUE TO <i>hypertensive cerebral disease</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i>		(c) <i></i>					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D.</i>		20f. (City or town) (County) (State) <i>1 W. Overlea Ave. BALTO. Md. 12-16-57</i>	
21. I certify that I attended the deceased from <u>11-24-53</u> , 19 <u>19</u> , to <u>12-16-57</u> , 19 <u>19</u> , that I last saw the deceased alive on <u>12-15</u> , 19 <u>57</u> , and that death occurred at <u>4:30 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Overlea, BALTO. MD.</i>							
ACTUAL SIGNATURE <i>Rigley</i>		DATE SIGNED <i>12-16-57</i>					
PHYSICIAN'S NAME (Type) <i>Dr. Richard R. Rigler</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>12/21/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Ashbury</i>		22d. LOCATION (City, town, or county) (State) <i>Towson, BALTO. MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.M. L. Schuttmann - 1701 21st &amp; Calhoun St. BALTO. MD.</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR DATE <i>DEC 19 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mrs. Kephnerday</i>	

BLAU V. S.  
DEC 19 1968  
FEDERAL BUREAU OF INVESTIGATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12800

## 12815 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>M.D.</b>		b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>35 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHITE MARSH (BALTO, 20)</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PARADISE NURSING HOME</b>		e. STREET ADDRESS <b>MOHRS LANE &amp; POLASKI Hwy</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
NAME OF DECEASED (Type or print)	First <b>MARY</b>	Middle <b>ELIZABETH</b>	Last <b>JONES</b>	4. DATE OF DEATH <b>12/7/57</b>	Month <b>12</b>	Day <b>7</b>	Year <b>1957</b>		
5. SEX <b>FEM</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 APRIL 1888</b>	9. AGE (In years last birthday) <b>69 yrs</b>	10. UNDER 1 YEAR IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N. CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>CARR JACKSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY D. DRINKLEY</b>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>JAMES H. JONES, SAME</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) DUE TO (c)		Hemiplegic Right.		Generalized Arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) <b>11/3/57</b>	20f. (City or town) <b>12/7/57</b>	(County)	(State)			
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 1045 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>1303 Frederick Rd</b>		DATE SIGNED <b>12/7/57</b>					
ACTUAL SIGNATURE <i>W. E. McGreath</i>	M.D.	PHYSICIAN'S NAME (Type) <b>W. E. McGreath</b>		22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/10/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>JONES FAMILY PLOT</b>	22d. LOCATION (City, town, or county) <b>Rural (SUNBURY, N.C.)</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walt Cook, Knobly, Knobly, Md.</i>		ADDRESS <b>Walt Cook, Knobly, Knobly, Md.</b>		24a. REC'D BY REGISTRAR <b>REG 57</b>		24b. REGISTRAR'S SIGNATURE <i>W. E. McGreath</i>		DATE	

DU MAU V. S

3

LAUREL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

128047  
12 8047

## 12726 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b>		2. USUAL RESIDENCE (Where Deceased lived If institution, Residence before admission) a. STATE <b>Md</b>	
b. CITY OR TOWN (If outside corporate limits, write CITY and give nearest town) <b>Balto Highlands</b>		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not hospital, give street address) OR INSTITUTION <b>2701 Yarmall Road.</b>		e. STREET ADDRESS <b>2701 Yarmall Road</b>	
f. FIRST <b>OLYMPIA-ELIZABETH KEIL</b>		g. MIDDLE Last Month Day Year <b>Dec 11 1957</b>	
h. COLOR OR RACE <b>Female White</b>		i. DATE OF BIRTH <b>Apr 8, 1874</b>	
j. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		k. AGE (in years less birthday) <b>83 yrs.</b>	
l. IF UNDER 1 YEAR Months <b>0</b>		m. IF UNDER 24 HRS Days <b>0</b>	
n. HOURS <b>0</b>		o. MIN. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife.</b>		10b. KIND OF BUSINESS, OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>Florida</b>	
13. FATHER'S NAME <b>John Pierce</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Clark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Charles E. Keil - Mulberry Rd. Baltimore</b>		Address <b>O.S. 1000 Mulberry Rd. Baltimore</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Generalized Arteriosclerotic Cardiovascular Disease</b>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>679 W. Washington Blvd.</b>		20f. (City or town) <b>Baltimore</b> (County) <b>Md.</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>10/19</b> , 19 <b>57</b> , to <b>12/11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12/11</b> , 19 <b>57</b> , and that death occurred at <b>679 W. Washington Blvd.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b>		DATE SIGNED <b>Joseph G. Laukitis</b>	
ACTUAL SIGNATURE <b>Joseph G. Laukitis</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Joseph G. Laukitis, M.D.</b>		Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 14, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Western</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Seufel</b>		ADDRESS <b>5311 Edmundson Ave.</b>	
		RECD BY REGISTRAR DATE <b>DEC 16 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>Geo M. Kephys</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DUNEAU V. S.

DEC 1 1957

REGEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12816 CERTIFICATE OF DEATH

12802

Reg. Dist. No.

1 PLACE OF DEATH  
o. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Fort Howard

c. LENGTH OF STAY IN 1b  
41 daysd. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

Veterans Administration Hospital

3 NAME OF  
DECEASED  
(Type or print)First  
CARROLLMiddle  
A.Last  
KETTLE4. DATE  
OF  
DEATH

December 20

Month  
Year  
1957

5 SEX

Male

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

8. DATE OF BIRTH

12/13/10

9. AGE (In years  
lost birthday)47  
yrs

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS

Days

12. Day

Hours

13. Year

Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10b. KIND OF BUSINESS OR INDUSTRY

Trucking Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Carroll Kettle

14. MOTHER'S MAIDEN NAME

Nora Peach

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes or no; or unknown)  
Yes

(If yes, give war or dates of service)

WWII

16. SOCIAL SECURITY NO.

215-10-8520

17. INFORMANT

Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a)

CARCINOMATOSIS PRIMARY SITE LUNG, LEFT

INTERVAL BETWEEN  
ONSET AND DEATH  
UNKNOWN

1621

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause first.

(b)

DUE TO

(c)

Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. 19  
p. m.20d. INJURY OCCURRED  
While at work  Not while at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from November 9, 1957, to December 20, 1957, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

SPECIAL  
EXAMINER

M.D. VAN Fort Howard, Maryland

12/20/57

PHYSICIAN'S  
NAME (Type) C.J. PAPASTRAT, M.D.22a. BURIAL, CREMATION,  
REMOVAL (Specify)  
Burial22b. DATE THEREOF  
Dec. 23" 195722c. NAME OF CEMETERY OR CREMATORIUM  
Lorraine Park Cemetery22d. LOCATION (City, town, or post office)  
Dogwood Rd., Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

Willis Lamoreau

ADDRESS 4510 Liberty  
Heights Ave.24a. REC'D BY REGISTRAR  
DATE ~24b. REGISTRAR'S SIGNATURE  
D.L. Farber

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Remove and file the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SUMMER V. S.

DEC 23 1957

LIBRARY  
SUMMER V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Medical examiner notified  
and released body. **12727 CERTIFICATE OF DEATH**

1280342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Write <del>where</del> and I resided if institution. Residence before admission) b. STATE <b>MARYLAND</b> <b>404 N. Rolling Road,</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>	c. LENGTH OF STAY IN lb <b>4 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 28, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Relay Hill Hospital</b>		d. STREET ADDRESS <b>1404 N. ROLLING RD.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Horace</b>	Middle <b>McClelland</b>	Last <b>King</b>
4. DATE OF DEATH	Month <b>12</b>	Day <b>26</b>	Year <b>1957</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 7-1920</b>
9. AGE (In years last birthday) <b>37 yrs</b>		10. IF UNDER 1 YEAR Months <b>3</b>	11. IF UNDER 24 HRS. Days <b>18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none at present</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>Park Avenue, New York City</b>
12. CITIZEN OF WHAT COUNTRY? <b>Citizen U.S.A.</b>			
13. FATHER'S NAME <b>C. Leroy King</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>414-26-4143</b>	17. INFORMANT Address <b>Mother: Mrs. John S. Albert / Ridgeway 7-7416</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Alcoholism with delirium</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last <b>50 d. i.</b>			
(b) <b>Possible Barbiturate intoxication</b>			
DUE TO  Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last <b>Chronic Alcoholism</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month <b>Dec.</b>	Day <b>23</b>	Year <b>1957</b>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>DORSEY</b>	(County) <b>M.D.</b>
21. I certify that I attended the deceased from <b>Dec. 23, 1957</b> to <b>Dec. 26, 1957</b> , that I last saw the deceased alive on <b>Dec. 26, 1957</b> , and that death occurred at <b>5:30A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lewis P. Gundry</b>		ADDRESS (Street, city or town, state) <b>ADDRESS</b>	
PHYSICIAN'S NAME (Type) <b>Lewis P. Gundry, M.D.</b>		DATE SIGNED <b>1/1/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>DEC. 28/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>MEADOW RIDGE</b>	22d. LOCATION (City, town, or county) <b>DORSEY M.D.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WILKE FUNERAL DIR. 4101 EDMONDSON</b>		ADDRESS <b>AVE.</b>	24a. REC'D BY REGISTRAR <b>DATE 1/1/57</b>
		AVE.	24b. REGISTRAR'S SIGNATURE <b>Mr. John M. Trickey</b>

SUMEAU Y.

1957

COLVILLE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'Pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12817 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 12804
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3yrllmth12dys</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Larchmont, Maryland</b>		d. STREET ADDRESS <b>2505 Poplar Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>										
3. NAME OF DECEASED (Type or print) <b>Florence</b>		First	Middle	Last	4. DATE OF DEATH <b>A. Knight</b>	Month	Day	Year	Dec. 5 19 57	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/9/18-</b>	9. AGE (In years, last birthday) <b>84? yrs.</b>	10. UNDER 1 YEAR Months <b>8</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. MIN. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular disease</b> DUE TO (c) <b>Fracture right hip</b> <b>Accident</b>										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Roger Anderson Splint use &amp; Cast Symptom</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, or Item 20.) <b>Pt. fell from bench on 11-12-57 sustaining an intertrochanteric frac. of rt.hip</b>								
20c. TIME OF INJURY Hour <b>1:30</b> p.m.		Month, Day, Year <b>11-12 19 57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>		20f. (City or town) <b>Catonsville</b>	(County) <b>28, Md.</b>	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE <i>George M. Kieffer</i>		DATE SIGNED <b>12-5-57</b>								
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward J. Bennett Jr. Esq.</i>		ADDRESS		24a. REC'D BY REGISTRAR <b>DEC 9 '57</b>		24b. REGISTRAR'S SIGNATURE <i>Dee L. Smith</i>				

BELMONT V. S

WILLIAM BELMONT

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12805  
38FOR STATE  
HEALTH DEPT.

## 12818 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Towson		d. STREET ADDRESS	
c. LENGTH OF STAY IN 1b				e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> xx	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		1205 Merediths Ford Road			
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	
Mr. Le Roy		J.	Koeneke	December 25th 1957	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH	9. AGE (In years last birthday) 46 yrs	
male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	IF UNDER 1 YEAR IF UNDER 14 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clerk, Continental Can Co				Baltimore, Maryland USA	
13. FATHER'S NAME		14. MOTHER'S MIDDLE NAME		12. CITIZEN OF WHAT COUNTRY?	
Charles Koeneke		Catherine Dressler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT	
(If yes, give war or dates of service)				Mrs. Virginia Koeneke, 2227 Kentucky Av	
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Thrombosis Sudden			
4. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b)					
5. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Charles P. Donnelly</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>Charles P. Donnelly</i>		DATE SIGNED 12/26/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/57		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Road.		24a. REC'D BY REGISTRAR DEC 30 1957	
				24b. REGISTRAR'S SIGNATURE Nigel Gray	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12819 CERTIFICATE OF DEATH

12806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lakesville</i>	c. LENGTH OF STAY IN 1b <i>1 week</i>	b. COUNTY <i>Lakesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3503 Midfield Road</i>	e. STREET ADDRESS <i>3503 Midfield Road</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Irving M Kolker</i>	First: <i>Irving</i> Middle: <i>M</i> Last: <i>Kolker</i>	4. DATE OF DEATH Month <i>12</i> Day <i>14</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>President</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Lumber</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Monish</i>		14. MOTHER'S MAIDEN NAME <i>Faga</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>Rosa Kolker - same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>four seconds</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY. Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec. 14, 1957</i> to <i>Dec. 14, 1957</i> , that I last saw the deceased alive on <i>Dec. 14, 1957</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John H. Trescher</i>		ADDRESS (Street, city or town, state) <i>1035 N Calvert St Baltimore Md</i>	
PHYSICIAN'S NAME (Type) <i>John H. Trescher</i>		DATE SIGNED <i>Dec. 15, 1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-16-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington</i>		22d. LOCATION (City, town, or county) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Jr 2100 Eutaw Place</i>		24a. REC'D BY REGISTRAR DATE <i>FC 18 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>Dorothy Lewis</i>	

EDWARD A. E.

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EDWARD A. E.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 12721 CERTIFICATE OF DEATH

12807

Reg. Dist. No. 41

<b>1. PLACE OF DEATH</b> COUNTY Baltimore MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Dundalk LENGTH OF STAY (In this place)				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dundalk STREET ADDRESS 1 ADDRESS (If rural give location) 7016 Dunhill Rd.			
<b>3. NAME OF DECEASED</b> (First) FRANK (Middle) KOPECNI (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) Dec. 12, 1957			
5. SEX Male	6. COLOR OR RACE Caucasian	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH October 10, 1883	9. AGE at birthday 74 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) brick layer			10b. KIND OF BUSINESS OR INDUSTRY Steel	11. BIRTHPLACE (State or foreign country) Czechoslovakia	12. CITIZEN OF WHAT COUNTRY? U.S. A.		
13. FATHER'S NAME John Kopecni				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Anthony P. Kopecni 7016 Dunhill Rd.			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> 4. IMMEDIATE CAUSE (A) <i>Arterio - Ocularis Cardiac Vas Disease - 5 yrs</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>Bronchitis + Pulm. Emphysema</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, etc.) OF INJURY (street, office, shop, etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from Nov. 19, 1957, to Dec. 12, 1957, that I last saw the deceased alive on Dec. 11, 1957, and that death occurred at 6:00 P.M. from the causes and on the date stated above.</b> <b>STANTEE</b> <i>D. Edwards M.D.</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 14, 1957	NAME OF CEMETERY OR CREMATORIALy		LOCATION (City, town, or county) (State) Baltimore, Md.		
24. REG'D BY REGISTRAR				REGISTRAR'S SIGNATURE <i>J. M. Kelley</i>		25. FUNERAL DIRECTOR'S SIGNATURE	
DATE						ADDRESS	
						Ullrich Funeral Homes, Balt., Md.	

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12808

**Reg. Dist. No.**

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		b. COUNTY Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR [INSTITUTION] Spring Grove State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Adelaide		First	Middle	Last	4. DATE OF DEATH Month 12 Day 7 Year 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-1875		9. AGE (In hours 1 day 1 year) 82 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland, U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME George E. Nicholson		14. MOTHER'S MAIDEN NAME Eliza Musgrove				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Alton Kratz (Son) 332 Lambeth Road Catonsville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) 4251 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arterioscler. Cardi. Vasc. Disease						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Balto. Md.	(County)	(State)
21. I certify that I attended the deceased from 1/28, 1957, to 12/7, 1957, that I last saw the deceased alive on 12/7, 1957, and that death occurred at 3:30 A.M. from the causes and on the date stated above ACTUAL SIGNATURE Stella Wachler M.D. ADDRESS (Street, city or town, state) Spring Grove State Hosp. DATE SIGNED 12/7/57 PHYSICIAN'S NAME (Type) STELLA WACHSLER Catonsville, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 10/57	22c. NAME OF CEMETERY OR CREMATORIUM Western Cemetery	22d. LOCATION (City, town, or county) Balto. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave/		ADDRESS 4101 Edmondson Ave/	24a. REC'D BY REGISTRAR DEC 10 57	24b. REGISTRAR'S SIGNATURE P. J. Deacon		

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12821

## CERTIFICATE OF DEATH

12809

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 116 Forest Avenue	
		d. STREET ADDRESS 116 Forest Avenue #28	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ANNIE	Middle LAVINIA	Last KRIEB
4. DATE OF DEATH	Month Dec.	Day 7	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME William F. Cain		14. MOTHER'S MAIDEN NAME Lavinia E. Glass	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Theodore Clark-116 Forest Avenue #28		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X myocardial insufficiency DUE TO arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertensive, cardio-vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 20, 1944, to Dec. 7, 1957, that I last saw the deceased alive on Dec. 7, 1957, and that death occurred at 10:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George A Knipp M.D.		ADDRESS (Street, city or town, state) 416 Edmondson Ave Baltimore, Md. DATE SIGNED Dec 8 1957	
PHYSICIAN'S NAME (Type) George A Knipp M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 12/10/57		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery	
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, North & Pa. Ave.		24a. REC'D. BY REGISTRAR DEC 10 1957 DATE	
		24b. REGISTRAR'S SIGNATURE	

S. A. G. M.

DEC

1952

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12822 CERTIFICATE OF DEATH

12810

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home				d. STREET ADDRESS 3501 Calloway Ave.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First ELLEN	Middle BARBARA	Last KUNKEL	4. DATE OF DEATH	Month Dec.	Day 4	Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1890	9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John Grissinger		14. MOTHER'S MAIDEN NAME Sarah Jane Smith						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO		17. INFORMANT Mr. Irvin T. Kunkel - 2113 Southland Rd.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 day				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		Central Hemorrhage						
DUE TO cause (b)		Cardiovascular Disease		6 mo				
DUE TO cause (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>11/10</u> alive on <u>11/11</u> , and that death occurred at <u>12:00 P.M.</u> on <u>11/12</u> , 19 <u>57</u> , that I last saw the deceased actual signature <u>Joseph G. Laukaitis</u> M.D. <u>679 Washington Blvd.</u> <u>Balto. 30, Md.</u>				ADDRESS (Street, city or town, state) <u>679 Washington Blvd.</u> DATE SIGNED <u>12/6/57</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/7/57		22c. NAME OF CEMETERY OR CREMATORIUM Emanuel Cem.		22d. LOCATION (City, town, or county) Lewisberry, Penna.		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Viskner &amp; Sons</u>		ADDRESS <u>17th and</u>		24a. REC'D BY REGISTRAR DATE DEC 9 '57		24b. REGISTRAR'S SIGNATURE <u>John J. Viskner</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be retained with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. GARDNER



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

Reg. Dist. No. **12811**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6001 Gwynn Oak Ave.</b>		d. STREET ADDRESS <b>6001 Gwynn Oak Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Ralph</b>	Middle	Last <b>Lange</b>	4. DATE OF DEATH	Month <b>Dec.</b>	Day <b>23</b>	Year <b>19 57</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1877</b>	9. AGE (In years lost birthday) <b>80 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Lange</b>		14. MOTHER'S MAIDEN NAME <b>Florence Speleshouse</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Mrs. Florence Lange - 6001 Gwynn Oak Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>- Generalized Arterio - Sclerosis -</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>	
(b) DUE TO <b>- Generalized Arterio - Sclerosis -</b>						<b>5 yrs.</b>	
(c) DUE TO <b>- Cerebral Thrombosis -</b>						<b>1 wks. -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arthritis of spine -</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>Dec. 7, 1957</b> , to <b>Dec. 23, 1957</b> , that I last saw the deceased alive on <b>Dec. 22, 1957</b> , and that death occurred at <b>12:27 PM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>4108 Liberty Hts Ave-Balto-Md</b>		DATE SIGNED <b>12-23-57</b>	
ACTUAL SIGNATURE <b>Earl L. Chambers</b>							
PHYSICIAN'S NAME (Type) <b>Earl L. Chambers -</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>12/26/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Towson Park Crem.</b>	22d. LOCATION (City, town, or county) <b>Balto., Md.</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elmer J. Pickover &amp; Sons</b>	ADDRESS <b>Baltimore, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>12/26/57</b>	24b. REGISTRAR'S SIGNATURE <b>Dr. John Martin</b>				

BUREAU Y. S

DEC - 11 - 1968

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12824

## CERTIFICATE OF DEATH

12812

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEY'SVILLE</b>	c. LENGTH OF STAY IN 1b <b>20 YEARS</b>	b. COUNTY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>	d. STREET ADDRESS <b>4201 RIDGEWOOD AVE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>AMELIA</b>	First <b>A</b>	Middle <b>MARY</b>	Last <b>LANTZ</b>	
4. DATE OF DEATH <b>FE</b>	Month <b>12</b>	Doy <b>19</b>	Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-9-1867</b>	
9. AGE (In years last birthday) <b>90 yrs</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>FREDERICK WIENEKE</b>	14. MOTHER'S MAIDEN NAME <b>KATHERINE WAGNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Frank L. Smith Jr - Cockeysville, Md</b>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio-Sclerotic Cardio</b> 42° DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years.</b>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Cockeysville</b>	(County) (State)
21. I certify that I attended the deceased from <b>7-19</b> , 1954, to <b>12-18</b> , 1957, that I last saw the deceased alive on <b>12-18</b> , 1957, and that death occurred at <b>12:40 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b> DATE SIGNED <b>Frank L. Smith Jr - 1/68</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>12-21-57</b> 22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cemetery</b> 22d. LOCATION (City, town, or county) <b>Baltimore</b> (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		ADDRESS <b>William Cook, Inc., 1217 St. Paul Street</b>	24a. REC'D BY REGISTRAR <b>DEC 6 1957</b>	24b. REGISTRAR'S SIGNATURE <b>✓</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ELLENDALE V. S.

DEC 23 1957



12813

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12825

Reg. Dist. No. 23

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dolfield Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22, i.d.	
3. NAME OF DECEASED (Type or print) First Stephen Middle Paul Lepus Jr.		4. DATE OF DEATH Month Dec. Day Year Dec. 14 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH	9. AGE (In years last birthday) 23 yrs.
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Jan. 19, 1934	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Stephen Lepus Sr.		14. MOTHER'S MAIDEN NAME Helen Loneala	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
Yes W.W.2		Robert Lepus, 34 Riverside Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
none			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hooked hose onto automobile exhaust & ran same in car window.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Dec. 10 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods-Dolfield Rd., Owings Mills, Baltimore, Md.
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>D. D. Caples</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-14-57
EXAMINER'S NAME (Type) D. D. Caples, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 17, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart of Mary	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kaczorowski Funeral Home	ADDRESS 2525 Fleet St Baltimore, Md.	24a. REC'D BY REGISTRAR DATE 12-14-57	24b. REGISTRAR'S SIGNATURE Mary B. Eline

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12826

## CERTIFICATE OF DEATH

Reg. Dist. No.

12814

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		d. STREET ADDRESS		3606 Clarendon Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
MALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	-	61	Months	Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY			
Owner		Tunical Doctor		Maryland		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Max Levinson		Beatrix J. Weitz							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
-		-		PT. S record					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiovascular disease</u>   INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.   ONSET AND DEATH DUE TO <u>Coronary disease</u> .  (b) <u>Atherosclerosis, generalized</u> DUE TO <u>Arteries</u> . (c) <u>Arteries</u> .									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  - nose -   19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  - nose -							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from 12-2, 1957, to 12-24, 1957, that I last saw the deceased alive on 12-27, 1957, and that death occurred at 9:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Sierra Weiszler M.D.</u> DATE SIGNED <u>12/27/57</u> PHYSICIAN'S NAME (Type) <u>D.P. S. WEISZLER</u> ADDRESS <u>Catonsville 20 bd</u>									
22d. BUR AL. CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)	
Cremation		12/27/57		Hebrew Friendship		Baltimore, Md.			
23. FUNERAL/DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
John J. Leonard		1124 26th St. North Ave		DEC 30 '57		John J. Leonard			

1951

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ALLEGRO

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; page 4  
may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12815  
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## .12827 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Balto.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X) Baltimore, Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 3 months 25 days		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 406 Register Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Carrie		First	Middle	Last	4. DATE OF DEATH December 5 1957	Month	Day	Year			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1870		9. AGE (in years last birthday) 87 yrs	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME William Bald		14. MOTHER'S MAIDEN NAME Pauline Klein									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 422.1						INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Arteriosclerotic cardiovascular disease									
DUE TO (c)		Arteriosclerosis, generalized and severe									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore	(County)	(State)			
21. I certify that I attended the deceased from Nov. 27, 1957, to Dec. 5, 1957, that I last saw the deceased alive on Dec. 5, 1957, and that death occurred at 3:15 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE Stella Wachsler		M.D. SPRING GROVE STATE HOSPITAL				12-5-57					
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-7-57		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Ev. W. Jenkins		ADDRESS 4905 York Road		Inc.		24a. REC'D BY REGISTRAR DATE 12/6/57	24b. REGISTRAR'S SIGNATURE A. J. Heidrich				

PUERTO RICO

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RECEIVED  
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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12817

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b <b>54</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		d. STREET ADDRESS <b>318 Oriole Avenue</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bank of Back River.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>THOMAS JEFFERSON LYNN</b>		First	Middle	Last	4. DATE OF DEATH <b>December 17 1957</b>	Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 29, 1885</b>	9. AGE (In years on birthday) <b>72</b>	yrs	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WEAVER.</b>		11. BIRTHPLACE (State or foreign country) <b>PHILADELPHIA, PA.</b>		12. CITIZEN OF WHAT CO INTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>WILLIAM LYNN</b>		14. MOTHER'S MAIDEN NAME <b>MATILDA</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>160-09-0214</b>		
17. INFORMANT <b>CATHERINE M. LYNN</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning, Found Drowned.</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (d)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) <b>Found drowned.</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>12/17 1957</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Back River</b>		
20e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20f. (City or town) <b>Baltimore</b>		(County) <b>Md.</b>		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> <b>Paul F. Guerin, M.D.</b>								
ACTUAL SIGNATURE <i>Paul F. Guerin</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNATURE <b>12/18/57</b>				
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-21-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>NEW CATHEDRAL CEM</b>		22d. LOCATION (City, town, or county) <b>OLD FREDERICK RD., BALTO., MD.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Geiler</b>		ADDRESS <b>901 S. CONKLING ST., BALTO., MD.</b>		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <b>Edith Kaurley</b>		
VS A15ME 5M 2/47								

Y. A. HAU

DEC 22

Y. A. HAU

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12828 CERTIFICATE OF DEATH

12818

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>3214 Kanyon Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>500 Fairway Court</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>MARGARET</b>	Middle <b>LYNCH</b>	Last	4. DATE OF DEATH	Month <b>December</b>	Day <b>11</b>	Year <b>1957</b>
S. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 18, 1883</b>	9. AGE (In years lost birthday) <b>74</b> yrs	IF UNDER 1 YEAR Months <b>7</b>	IF UNDER 24 HRS Days <b>14</b>	IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Bauer</b>		14. MOTHER'S MAIDEN NAME <b>Lena Frederick</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
				<b>John C. Lynch, husband, above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <span style="margin-left: 100px;">INTERVAL BETWEEN ONSET AND DEATH</span>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tranx</b>							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized metastasis, abdominal</b> (c) <b>Carcinoma of breast.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <span style="float: right;">19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></span>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Generalized metastasis</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>201 Yulewood</b>		20f. (City or town) (County) (State) <b>Baltimore</b> (Md.) (Md.)	
21. I certify that I attended the deceased from <b>June 1, 1957</b> to <b>Dec 11, 1957</b> , that I last saw the deceased alive on <b>Dec 8, 1957</b> , and that death occurred at <b>900P M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Chas. E. Carr, Jr., M.D.</b> ADDRESS (Street, city or town, state) <b>201 Yulewood</b> DATE SIGNED <b>Dec 13, 1957</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/14/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b> (Md.) (Md.)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek funeral Home</b> <b>3331 Francis Lane</b>		ADDRESS		24a. REC'D. BY REGISTRAR <b>REC'D. 12/15/57</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. E. Carr, Jr., M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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REGELVÉO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

12818

12830

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with  
 the record prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>MARYLAND</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>19 yr 8 mth 16 days</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>									
3. NAME OF DECEASED (Type or print) <b>Rosie</b>		d. STREET ADDRESS <b>UNKNOWN</b>									
4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>unknown</b>	9. AGE (In years last birthday) <b>60?</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Month <b>December</b>	13. Day <b>1</b>	14. Year <b>1957</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Martin Mach</b>		14. MOTHER'S MAIDEN NAME <b>Mary Giza</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b>		DUE TO		INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Arteriosclerotic heart disease</b>		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>Nov. 30, 1957</b> , to <b>Dec. 1, 1957</b> , that I last saw the deceased alive on <b>Dec. 1, 1957</b> , and that death occurred at <b>1:00 p.m.</b> from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>Stella Wachsler</b>		M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED					
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>				<b>SPRING GROVE STATE HOSPITAL 12-2-57</b>							
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 4, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Stanislaus Cemetery</b>		22d. LOCATION (City, town, or county) <b>1300 Dundalk Ave +Balto, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>George A. Weber 705-8 Ann st</b>		ADDRESS <b>George A. Weber 705-8 Ann st</b>		24e. REC'D BY REGISTRAR <b>DEC 4 '57</b>		24f. REGISTRAR'S SIGNATURE <b>DeLoach</b>					

7. Island

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MAPS 1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12831

## CERTIFICATE OF DEATH

Reg. Dist. No.

12819

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that this death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aero Acres Rural</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aero Acres Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>48 Rt. Wing Drive</u>		d. STREET ADDRESS <u>48 Rt. Wing Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Arthur H. Maddox</u>	Middle	Last	4. DATE OF DEATH	Month <u>12/14/57</u>	Day	Year <u>19</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1/29/1881</u>	9. AGE (In years last birthday) <u>76 yrs</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Land Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Pushrod Maddox</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Weekly</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <u>Mrs. Bessie L. Maddox 48 Rt. Wing Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month <u>Dec.</u> <u>1957</u>	Day <u>14</u>	Year <u>1957</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>422 Eastern Ave between 21 and 23</u>	20f. (City or town) <u>Perry Hall</u>	(County) <u>Marlboro</u> (State) <u>Md.</u>
21. I certify that I attended the deceased from <u>Dec. 10</u> , 1957, to <u>Dec. 14</u> , 1957, that I last saw the deceased alive on <u>Dec. 14</u> , 1957, and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>M.D. 422 Eastern Ave between 21 and 23</u> DATE SIGNED <u>12/14/57</u>							
ACTUAL SIGNATURE <u>James H. G. Lee</u>		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/57</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>St. Michaels Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Perry Hall</u> <u>Marlboro</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lorraine Funeral Home 7401 Belair Rd</u>		ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR DATE <u>12/17/57</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Farley</u>	

BRUNN V. S

25  
LAW

1970

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12832

## CERTIFICATE OF DEATH

12821

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea, Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea, Rural</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>211 Fullerton Avenue</b>		d. STREET ADDRESS <b>1201 Fullerton Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Augusta</b>	Middle <b>Mallon</b>	Last <b>74</b>	4. DATE OF DEATH <b>Dec. 11 1957</b>	Month <b>Dec.</b>	Day <b>11</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1883</b>	9. AGE (in years last birthday) <b>74 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seamstress</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Misikofski</b>				14. MOTHER'S MAIDEN NAME <b>Anna Bunk</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <b>220-30-3604</b>		17. INFORMANT <b>Miss Martha Mallon</b>		Address <b>4201 Fullerton Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b)  DUE TO  (c)				INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>  <b>Congestive heart failure</b>  <b>arterio sclerotic heart disease</b>  <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <b>Hypertension</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2 W. University Pkwy</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Howard County</b>		(County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2 W. University Pkwy</b>							
ACTUAL SIGNATURE <b>William J. Fritz</b>		M.D. <b>Howard County</b>		DATE SIGNED <b>12/13/57</b>			
PHYSICIAN'S NAME (Type) <b>William Fritz</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
22b. DATE THEREOF <b>12/13/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. John's Luth. Cem.</b>		22d. LOCATION (City, town, or county) <b>Howard County</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lazarus Funeral Home</b>		ADDRESS <b>2401 Belair Rd.</b>		24e. REC'D. BY REGISTRAR DATE <b>DEC 13 1957</b>		24f. REGISTRAR'S SIGNATURE <b>Mrs. V. L. Redden</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REEDAU V. A.

1957



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12822

## 12833 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c LENGTH OF STAY IN 1b 8mths6dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL	d STREET ADDRESS 1000 S. Caton Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)  Annie	First E. Middle	4. DATE OF DEATH Dec. 7	Month Day Year 19 57
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 1876
9. AGE (In years last birthday) 81 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME NURSE - RET.	11. KIND OF BUSINESS OR INDUSTRY HOSPITAL	12. BIRTHPLACE (State or foreign country) Maryland
13. CITIZEN OF WHAT COUNTRY? U. S. A.	14. MOTHER'S MAIDEN NAME Ann		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO Unknown	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 21, 1957, to Dec. 7, 1957, that I last saw the deceased alive on Dec. 7, 1957, and that death occurred at 11:50 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler	M.D.	ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	DATE SIGNED 12-9-57
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.	Catonsville 28, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-11-57	22c. NAME OF CEMETERY OR CREMATORIUM Arlene Cem.	22d. LOCATION (City, town or county) Baltimore Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Garley Funeral Home - Catonsville, Md.	ADDRESS	24a. REC'D BY REGISTRAR DEC 12 '57	24b. REGISTRAR'S SIGNATURE C. J. Redick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MURRAY V. S

DEC 19 1972

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**12834 CERTIFICATE OF DEATH**

Reg. Dist. No. **12823 38**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riderwood</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riderwood</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8112 Rider Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Lila</b>	Middle <b>R.</b>	Last <b>March</b>
4. DATE OF DEATH	Month <b>December</b>	Day <b>27</b>	Year <b>19 57</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 3, 1867</b>
9. AGE (In years last birthday) <b>90</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Music Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Music</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>
13. FATHER'S NAME <b>William G. March</b>		14. MOTHER'S MAIDEN NAME <b>Jeanette Boyd MacLaughlin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Claire McDonnell Worthington, 8112 Rider Ave</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO-VASCULAR ACCIDENT</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>	
42.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Timonium, MD.</b>
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept. 1957</b> , to <b>Dec. 27, 1957</b> , that I last saw the deceased alive on <b>Dec. 21, 1957</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Timonium, MD.</b>			
ACTUAL SIGNATURE <b>William A. Pillsbury</b>		DATE SIGNED <b>12/27/57</b>	
PHYSICIAN'S NAME (Type) <b>William A. Pillsbury</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/30/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park</b>
22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, Inc 1050 N. York Rd, Towson</b>		24a. ADDRESS <b>12/30/57</b>	24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12824

## 12835 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore Co.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Georgia</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN lb <b>10 mos. 16 da.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Atlanta</b>		d. STREET ADDRESS <b>875 W. Paces Ferry Road, N. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sheppard &amp; Enoch Pratt Hosp. Towson 4, Md.</b>								
3. NAME OF DECEASED (Type or print)		First <b>Rembert</b>	Middle	Last <b>Marshall</b>	4. DATE OF DEATH <b>December 28</b>	Month <b>December</b>	Day <b>28</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1892</b>	9. AGE (In years last birthday) <b>65 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>law office</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Ella Holton</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W. I</b>		17. INFORMANT <b>Hospital records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177X</b> DUE TO <b>Palmer</b> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Generalized carcinomatosis</b> ONSET AND DEATH DUE TO <b>18 mon.</b> (c) <b>Carcinoma of prostate.</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> 20d. INJURY OCCURRED p. m. Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Atlanta,</b>		(County) <b>Atlanta,</b>	(State) <b>Ga.</b>	
21. I certify that I attended the deceased from <b>February 12, 1957</b> , to <b>Dec. 28, 1957</b> , that I last saw the deceased alive on <b>December 28, 1957</b> , and that death occurred at <b>10:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Harry M. Murdock, M.D.</b>								
DATE SIGNED <b>12/28/57</b>								
ACTUAL SIGNATURE <b>Harry M. Murdock, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Sheppard &amp; Enoch Pratt Hosp. Towson 4, Md.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 31, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>West View</b>		22d. LOCATION (City, town, or county) <b>Atlanta,</b> (State) <b>Ga.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>		ADDRESS <b>1900 Eutaw Place</b>		24a. REC'D. BY REGISTRAR <b>JAN 2 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Malvina Green</b>		
VS A1S (4) 1SM 9/55								

January 2009

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PERIODICALS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12836 CERTIFICATE OF DEATH

12825

Reg. Dist. No.

1. PLACE OF DEATH • COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN IB 2mths 29dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.	
3. NAME OF DECEASED (Type or print) Jessie F.		d. STREET ADDRESS 8601 - 49th Avenue	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 26/1863 UNKNOWN
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY At hoem	
10c. FATHER'S NAME UNKNOWN		11. BIRTHPLACE (State or foreign country) UNKNOWN Michigan	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. MOTHER'S MAIDEN NAME UNKNOWN Lucy Prentiss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or NO) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT unknown		Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last <i>Arteriosclerosis, generalized and severe</i>			
(b) DUE TO <i>Arteriosclerosis, generalized and severe</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 29, 1957, to Dec. 2, 1957, that I last saw the deceased alive on Dec. 2, 1957, and that death occurred at 7:15 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Stella Wachsler		DATE SIGNED 12-2-57	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		M.D. SPRING GROVE STATE HOSPITAL	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/1957	
22c. NAME OF CEMETERY OR CREMATORIUM Washington Nat'l Cem.		22d. LOCATION (City, town or county) Suitland, Pr. Geo. Co. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Tel. W. Chagares Co.		ADDRESS Lindale 3rd	
24a. REC'D BY REGISTRAR DATE DEC 9 '57		24b. REGISTRAR'S SIGNATURE C. L. Research	

SAVANNAH V. A.

DEC

WINTER 1968

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12826

12837

## CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Halethorpe (Westland Gardens)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4804 Eldon Green West and Gardens 27		d. STREET ADDRESS 4804 Eldon Green e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) George	First Middle Alvin	Last Mason	4. DATE OF DEATH December 7 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1889	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (ret'd)		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		
10c. BIRTHPLACE (State or foreign country) Mt. Vernon, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George B. Mason		14. MOTHER'S MAIDEN NAME Mary A. Scott		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give name or dates of service) W.W.I		16. SOCIAL SECURITY NO 217-01-0122 17. INFORMANT Bertie M. Mason, 4805 Eldon Garden		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 150X DUE TO CARCINOMA caused THRD ESOPHAGOUS & METASTASIS		INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), listing the under-lying cause last. (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on _____ and that death occurred at _____ from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL	John H. Shaw, M.D.		M.D. 5800 Edmondson Ave. # 28	
PHYSICIAN'S NAME (Type)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-10-57	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National	22d. LOCATION (City, town, or county) Baltimore (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS	24a. REC'D BY REGISTRAR DEC 11 1957	24b. REGISTRAR'S SIGNATURE Dr. George M. Kupper

Y.A.C.  
[REDACTED]

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12838 CERTIFICATE OF DEATH

12827  
38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>	c. LENGTH OF STAY IN 1b <b>TOWSON</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>	d. COUNTY <b>BALTIMORE</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>921 ELLENDALE DRIVE</b>	e. STREET ADDRESS <b>921 ELLENDALE DRIVE</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>EVELYN</b>	First <b>C</b>	Middle <b>MAST</b>	4. DATE OF DEATH Month <b>DEC.</b> Day <b>13</b> Year <b>1957</b>				
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1916</b>	9. AGE (In years (by birthday) <b>41</b> yrs.)	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>	12. IF UNDER 24 HRS Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>C. Elmer Blakeley</b>		14. MOTHER'S MAIDEN NAME <b>Anna E. Finn</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John Mast, Providence, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ADENOCARCINOMA OF OVARY</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>25 W. Pa. Ave.</b>		20f. (City or town) (County) (State) <b>Towson</b> (Baltimore) (Md.)	
21. I certify that I attended the deceased from <b>5/24</b> , 19 <b>57</b> , to <b>12/13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12/12</b> , 19 <b>57</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald L. Somerville</b>		ADDRESS (Street, city or town, state) <b>25 W. Pa. Ave.</b>		DATE SIGNED <b>12/13/57</b>			
PHYSICIAN'S NAME (Type) <b>DONALD L. SOMERVILLE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 16, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Moreland Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Parkville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons</b>		ADDRESS <b>Towson, Md.</b>		24a. REC'D BY REGISTRAR <b>Dec. 15, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>	

T A M I L

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12839 CERTIFICATE OF DEATH

Reg. Dist. No.

12828

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN TB <i>2 mo 13 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sheppard Enoch Pratt Hosp. 100 W. University Pkwy</i>		e. STREET ADDRESS <i>Baltimore - 10</i>			
3. NAME OF DECEASED (Type or print) <i>Thomas Branch Mc Adams</i>		4. DATE OF DEATH <i>Dec. 31</i>	5. MONTH Year <i>Month Day Year</i>		
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 12, 1879</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>President Union Trust</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Banking</i>	11. BIRTHPLACE (State or foreign country) <i>Richmond, Virginia</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>George B. Mc Adams</i>			
14. MOTHER'S MAIDEN NAME <i>Sarah Reade Branch</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If not, unknown) <input type="checkbox"/> (If yes, give war or date of service) <i>No.</i>			
16. SOCIAL SECURITY NO. <i>450-0</i>		17. INFORMANT <i>Hospital Records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO 450-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Serility</i> DUE TO (c) <i>Generalized Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>Term.</i> <i>3 yr t</i> <i>3 yr +</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Brain Syndrome due to Senile Brain Disease</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>55</i>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>55</i>	20f. (City or town) <i>55</i>	(County) <i>55</i>	(State) <i>55</i>
21. I certify that I attended the deceased from <i>Oct 18, 1957</i> to <i>Dec 31, 1957</i> , that I last saw the deceased alive on <i>Dec 31, 1957</i> , and that death occurred at <i>1105PM</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>W.W. Elgin</i>	PHYSICIAN'S NAME (Type) <i>W.W. Elgin</i>	M.D.	ADDRESS (Street, city or town, state) <i>Sheppard Pratt Hosp. 100 W. University Pkwy, Towson - 10, Md.</i>		
DATE SIGNED <i>1/1/58</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-3-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Hollywood Cemetery</i>	22d. LOCATION (City, town, or county) <i>Richmond, Va.</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins &amp; Sons Co. Inc.</i>	ADDRESS <i>1905 York Rd., Balt., Md.</i>	24a. REC'D BY REGISTRAR <i>VS A15 (4) 1SM 9/55</i>	24b. REGISTRAR'S SIGNATURE <i>Miss Mary</i>		

DILANO A. S.

MAN 4

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

12829

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon</b>		b. COUNTY <b>Balto.</b>	
c. LENGTH OF STAY IN 1b <b>5 Central Ave.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Glyndon</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5 Central Ave.</b>		d. STREET ADDRESS <b>5 Central Ave.</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b>J. McDonnell</b>	4. DATE OF DEATH Month <b>Dec.</b> Day <b>14</b> Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1896</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employed by Baltimore County</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James P. McDonnell</b>		14. MOTHER'S MAIDEN NAME <b>Julia Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.1 220-12-5956</b>	
17. INFORMANT <b>Mrs. Margaret G. McDonnell, Glyndon, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>	
4a. i DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Hypertensive Arteriosclerotic C-V Disease</b>		10 yrs.	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Hour a. n. <b>none</b>	Month 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>
21. I certify that I attended the deceased from <b>7-31-47</b> , 19_____, to <b>12-14-57</b> , 19_____, that I last saw the deceased alive on <b>12-14-57</b> , 19_____, and that death occurred at <b>10:30P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>X. D. Caples</b> M.D. <b>6 Hanover Rd.</b>		ADDRESS (Street, city or town, state) <b>Reisterstown, Md.</b> DATE SIGNED <b>12-16-57</b>	
22e. PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		22f. RECD BY REGISTRAR DATE <b>12-16-57</b>	
22b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 18, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>All Saints</b>	22d. LOCATION (City, town, or county) (State) <b>Reisterstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons</b>		24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>	
ADDRESS <b>Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>12-16-57</b>	

**ATTENTION PHYSICIANS:** This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PRIVACY V. S

DEC 1951

PRIVACY V. S

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

128312

Item: 16 Film G223 12/10/57 34 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		12. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		d. STREET ADDRESS <b>120 LANVALE ST.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ALBERT</b>	Middle <b>DAVID</b>	Last <b>McFAADDEN</b>	4. DATE OF DEATH <b>12 4 1957</b>	Month <b>12</b>	Day <b>4</b>	Year <b>1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/9/18</b>	9. AGE (In years (on birthday) yrs <b>39</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REAL ESTATE BROKER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALBERT D. McFADDEN</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN BURNS</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-03-1574</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS ACTIVE</b>		DUE TO <b>UOZK</b>		FAR ADVANCED ONSET AND DEATH <b>12 months</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		(c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>FATTY DEGENERATION OF LIVER</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/30, 1957</b> , to <b>12/4, 1957</b> , that I last saw the deceased alive on <b>12/3, 1957</b> , and that death occurred at <b>12:05 A.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <b>William Newcomer</b>		M.D.		Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>							
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Cremated Dec 7/17</b>		22b. DATE THEREOF <b>Deced July 17/17</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Reserve, Inc.</b>		22d. LOCATION (City, town, or county) (State) <b>Reserve, Inc.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sebastian Newcomer</b>		ADDRESS <b>108th Street Baltimore</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 8 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Jewell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BIRD

DEC 5 1957

LIBRARY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12842 CERTIFICATE OF DEATH

1283131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodlawn</i>	c. LENGTH OF STAY IN 1b <i>Woodlawn</i>	b. COUNTY <i>Balto.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1917 Hillside Ave.</i>	e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Woodlawn</i>	d. STREET ADDRESS <i>1917 Hillside Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Martha E. McGinnis</i>	First <i>Martha</i>	Middle <i>E.</i>	Last <i>McGinnis</i>
4. DATE OF DEATH <i>Dec. 24 1957</i>	Month <i>Dec.</i>	Day <i>24</i>	Year <i>1957</i>
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 12, 1887</i>
9. AGE (In years lost, birthday) <i>70 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Balto.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Vernon Sater</i>	14. MOTHER'S MAIDEN NAME <i>?</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Mr. Wm G. McGinnis Jr., 6411 Kingley Ave.</i>	Address <i>6411 Kingley Ave.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>421.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
Acute Pulmonary Edema Calypse Aortic Disease & Aortic Stenosis INTERVAL BETWEEN ONSET AND DEATH "2 hours 3 years			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. p. m. <i>19</i>	Month <i>Dec.</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>5907 Gwynn Oak Ave. #7</i>
21. I certify that I attended the deceased from <i>8-2</i> , 19 <i>55</i> , to <i>12-24</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12-23</i> , 19 <i>57</i> , and that death occurred at <i>4:12 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Leon Ashman</i>	M.D.		ADDRESS (Street, city or town, state) <i>5907 Gwynn Oak Ave. #7</i>
PHYSICIAN'S NAME (Type) <i>Leon Ashman</i>	DATE SIGNED <i>12-24-57</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec. 28, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olive</i>	22d. LOCATION (City, town, or county) <i>Randolstown, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Stansbury - 6411 Kingley Mill Rd.</i>	ADDRESS <i>6411 Kingley Mill Rd.</i>	24a. REC'D BY REGISTRAR DATE <i>Dec. 28, 1957</i>	24b. REGISTRAR'S SIGNATURE <i>John T. Stansbury</i>

ENNEAU Y.

DEC 20 1957

REGULATIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12832

**12843 CERTIFICATE OF DEATH**

Reg. Dist. No.

1. NAME OF DECEASED  
(Type or Print)

**Ethel Regina McNAMEE**

2. DATE  
OF  
DEATH

**Dec. 26, 1957**

3. PLACE OF DEATH

Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived if institution; maiden name if female)

Baltimore County

A STATE

**Maryland**

B COUNTY

**Baltimore**

5. FULL NAME OF (If not in hospital or institution, give street address or

HOSPITAL OR

INSTITUTION

location

before admission)

**424 Overbrook Road**

C CITY OR TOWN

**X Baltimore**

(If outside corporate limits, write RURAL and give

township)

6. LENGTH OF STAY IN BALTIMORE

Yr

Mos

Days

7. SEX

8. COLOR OR RACE

9. SINGLE MARRIED

WIDOW DIVORCED (Specify)

**Life**

**Female**

**White**

**Married**

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

**Housewife**

---

12. FATHER'S NAME

**William J. McLaughlin**

13. WAS DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no or unknown) (If yes, give war or date of service)

**No**

14. SOCIAL SECURITY NO

**None**

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

**(A) Carcinoma of colon with generalized  
metastasis**

DUE TO

**15 3X ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT

ML CERTIFICATION

IF OPERATION WAS RELATED TO

19A. DATE OF OPERATION

CAUSE OF DEATH ENTER IN PART I OR PART II

21D TIME (Month) (Day) (Year) (Hour)

OF INJURY

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

21E

21F

21G

21H

21I

21J

21K

21L

21M

21N

21O

21P

21Q

21R

21S

21T

21U

21V

21W

21X

21Y

21Z

21AA

21AB

21AC

21AD

21AE

21AF

21AG

21AH

21AI

21AJ

21AK

21AL

21AM

21AN

21AO

21AP

21AQ

21AR

21AS

21AT

21AU

21AV

21AW

21AX

21AY

21AZ

21BA

21BB

21BC

21BD

21BE

21BF

21BG

21BH

21BI

21BJ

21BK

21BL

21BM

21BN

21BO

21BP

21AQ

21AR

21AS

21AT

21AU

21AV

21AW

21AX

21AY

21AZ

21BA

21BB

21BC

21BD

21BE

21BF

21BG

21BH

21BI

21BJ

21BK

21BL

21BM

21BN

21BO

21BP

21AQ

21AR

21AS

21AT

21AU

21AV

21AW

21AX

21AY

21AZ

21BA

21BB

21BC

21BD

21BE

21BF

21BG

21BH

21BI

21BJ

21BK

21BL

21BM

21BN

21BO

21BP

21AQ

21AR

21AS

21AT

21AU

21AV

21AW

21AX

21AY

21AZ

21BA

21BB

21BC

21BD

21BE

21BF

21BG

21BH

21BI

21BJ

21BK

21BL

21BM

21BN

21BO

21BP

21AQ

21AR

21AS

21AT

21AU

21AV

21AW

21AX

21AY

21AZ

21BA

21BB

21BC

21BD

21BE

21BF

21BG

21BH

21BI

21BJ

21BK

21BL

21BM

21BN

21BO

21BP

21AQ

21AR

21AS

21AT

21AU

21AV

21AW

21AX

21AY

21AZ

21BA

21BB

21BC

21BD

21BE

21BF

21BG

21BH

21BI

INTERVAL BETWEEN  
ONSET AND DEATH

19.

20.

AUTOPSY?

YES  NO

21.

SIGNATURE

22.

ADDRESS

23.

DATE SIGNED

24.

BURIAL, CREMA-

TION, REMOVAL (Specify)

Burial

25.

NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery

Baltimore, Maryland

26.

LOCATION (City, town, or county)

(State)

27.

FUNERAL DIRECTOR

John A. Moran

28.

ADDRESS

3000 E. Baltimore St.

29.

DATE RECEIVED BY

LOCAL REGISTRAR

DEC 29 1957

30.

REGISTRAR'S SIGNATURE

Mark Gray

31.

ADDRESS

100 W. JEFFERSON

32.

DATE

12/27/57

BUREAU V.

JAN 2 19

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12833

33

12844

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orwings Mills, Maryland		c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18, Maryland		d. STREET ADDRESS 3815 Monterey Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood Training School				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Margay Louise		First Middle Last		4. DATE OF DEATH Meinert		Month	Day	Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/14/47		9. AGE (In years from birthday) 10 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jerome Eugene Meinert		14. MOTHER'S MAIDEN NAME Georigeanna Austin						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) no		16. SOCIAL SECURITY NO		17. INFORMANT Rosewood Records		Address		
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 10 days		
351X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Spastic Infantile Paralysis		DUE TO				since birth		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from 12/30, 19 57 to 12/30, 19 57, that I last saw the deceased alive on 12/30, 19 57, and that death occurred at 1:30 pm, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED 12/31/57
ACTUAL SIGNATURE Olive Reid Harris, M.D.								
PHYSICIAN'S NAME (Type) Olive Reid Harris, M.D.		Rosewood State Training School						
22a. BURIAL, CREMATION, REMOVAL (Specify) ✓ 12. 31. 57		22b. DATE THEREOF 12. 31. 57		22c. NAME OF CEMETERY OR CREMATORIUM v. of Md. Med. School		22d. LOCATION (City, town, or county) Baltimore, Md		(State)
23. FUNERAL DIRECTOR'S SIGNATURE F.H. Newell Inc. - Pikesville		ADDRESS		24a. REC'D BY REGISTRAR DATE 1/2/58		24b. REGISTRAR'S SIGNATURE Mary E. Kling		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

DUFREAU V. S.

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REGELIA EDITIONS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12845 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12834

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>29 yr 6 mo 26 dy s</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				
f. STREET ADDRESS <b>1006 Hanover Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Anna</b>	Middle <b>Moffitt</b>	Last Month Day Year <b>December 3 19 57</b>			
4. DATE OF DEATH	5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>2-10-??</b>	9. AGE (In years on birthday) <b>82? yrs.</b>	10. IF UNDER 1 YEAR Months Days <b>Hours Min.</b>	11. IF UNDER 24 HRS <b>Hours Min.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>unknown</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>George Rollhoff</b>	14. MOTHER'S MAIDEN NAME <b>Anna ??</b>	Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Records ; SPRING GROVE STATE HOSPITAL</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>900.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> DUE TO <b>(c)</b>	INTERVAL BETWEEN ONSET AND DEATH <b>acute cardiac failure</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pt. fell on steps on way to cafeteria sustaining fractured left hip.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour <b>6:45</b>	Month, Day, Year <b>11-20-57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	20f. (City or town) <b>Catonsville</b>	(County) <b>28, Md.</b>	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>George M. Kieffer</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>12-4-57</b>		
22a. BURIAL CREMATION, 22b. DATE THEREOF <b>BURIAL 12-6-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>NEW CATHEDRAL CEM. 4300</b>		22d. LOCATION (City, town, or county) <b>OLD FREDERICK RD. MD.</b>		(State) <b>BALTIMORE</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles S. Seiler</i>	ADDRESS <b>901 S. CONKLING ST. BALTIMORE, MD.</b>	24a. REC'D BY REGISTRAR DATE <b>DEC 9 '57</b>		24b. REGISTRAR'S SIGNATURE <i>Alt. Seiler</i>		

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SCHOOL OF

V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12846 CERTIFICATE OF DEATH

Reg. Dist. No.

1283538

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Md.		b. COUNTY		Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		d. STREET ADDRESS 315 E. North Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First SARA	Middle ROBERTA	Last MOONEY	4. DATE OF DEATH	Month Dec.	Day 11,	Year 1957				
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 10, 1876	81 yrs	Months	Days	Hours	Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?						
13. FATHER'S NAME James Miles		14. MOTHER'S MAIDEN NAME Elizabeth McFarland		15. SOCIAL SECURITY NO		16. INFORMANT		Address				
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) DUE TO  (c)		Coronary Thrombosis		Mr. Nelson F. Hurley - 111 Hollen Rd.		INTERVAL BETWEEN ONSET AND DEATH		Immediate		
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Chronic Arteriosclerosis						Indefinite		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Nov 22, 1947</u> , to <u>Dec 11, 1947</u> , that I last saw the deceased alive on <u>Dec 6th 1947</u> , and that death occurred at <u>2 AM</u> , from the causes and on the date stated above		ADDRESS (Street, city or town, state)		DATE SIGNED								
ACTUAL SIGNATURE Nathaniel M Beck		M.D. 2818 At Paul St Baltimore Md		Dec 11 1947								
PHYSICIAN'S NAME (Type) Nathaniel M Beck												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/13/57		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery		22d. LOCATION (City, town, or county) Balto.		(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Henry Pickover & Sons - Balto. 17th		ADDRESS		24a. REC'D BY REGISTRAR DATE 12/13/57		24b. REGISTRAR'S SIGNATURE Maile Gray						

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12836

## 12847 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 2mths20dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			d. STREET ADDRESS 415 Augusta Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Annie		First Middle Neuman	Last Muhlbaumer	4. DATE OF DEATH December 15	Month Day Year 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1873	9. AGE (In years, months, days) 84 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Catonsville, Md.		
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO Unknown		
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic cardiovascular disease			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 25, 1957, to Dec. 15, 1957, that I last saw the deceased alive on Dec. 15, 1957, and that death occurred at 12:50PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE Stella Wachsler		M.D. SPRING GROVE STATE HOSPITAL 12-15-57			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-1957		22c. NAME OF CEMETERY OR CREMATORIUM ST. MATTHEWS CEM. BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Truman Sachar		ADDRESS 3512 Frederick Ave. (29)		24a. REC'D BY REGISTRAR DATE DEC 17 1957	
				24b. REGISTRAR'S SIGNATURE Out of service	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1951



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12837

## 12848 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Balto., 4		c. LENGTH OF STAY IN 1b Approx. 2½ yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 117 Stevenson Lane		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Anna	Middle Beatrice	Last Murray	4. DATE OF DEATH December 10	Month December	Day 10	Year 1957
5. SEX <input checked="" type="checkbox"/> F	6. COLOR OR RACE <input checked="" type="checkbox"/> W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> December 14, 1880	9. AGE (in years last birthday) 7 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John McGinnis		14. MOTHER'S MAIDEN NAME Catherine Mulligan						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Admission Record		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Coronary Thrombosis		Coronary Insufficiency from Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 Months		
(b) DUE TO						8 Yrs		
(c)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>December</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>December 10, 1957</u> , and that death occurred at <u>Charles F. O'Donnell, M.D.</u> M., from the causes and on the date stated above				ADDRESS (Street, city or town, state)		DATE SIGNED <u>12/10/57</u>		
ACTUAL SIGNATURE CHARLES F. O'DONNELL, M.D.								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 12/13/57		22b. DATE THEREOF 12/13/57		22c. NAME OF CEMETERY OR CREMATORIUM St. Jos. Texas		22d. LOCATION (City, town, or county) Barto Co.		
24a. REC'D. BY REGISTRAR Date 12/13/57		24b. REGISTRAR'S SIGNATURE Mabel Gray						
26. FUNERAL DIRECTOR'S SIGNATURE Frederick J. Lohr		ADDRESS Greenwood & 23rd St. N.E.						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/55

BUREAU V. S.  
FBI - 1957  
GLENDALE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12849

## CERTIFICATE OF DEATH

Reg. Dist. No.

12838

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Baltimore</b>		c. LENGTH OF STAY IN 1b <b>1d.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>625 Warwick Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>AUGUSTA S. NAUMANN</b>		First	Middle	Last	4. DATE OF DEATH <b>DEC 16 1957</b>	Month	Day	Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/14/1880</b>	9. AGE (In years lost birthday) <b>77 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Herman F. Rahnis</b>		14. MOTHER'S MAIDEN NAME <b>Louise Holland</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>216-07-1014</b>		17. INFORMANT <b>Mrs. James Pearre 625 Warwick Rd.</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA</b> DUE TO 199.9 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. { (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10-15 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>MALNUTRITION</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) <b>1600 Wilkins Ave</b>		20f. (City or town) <b>Baltimore, Md.</b>		(County) <b>M.D.</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>OCTOBER 1957</b> to <b>DECEMBER 1957</b> , that I last saw the deceased alive on <b>16 DEC 1957</b> , and that death occurred at <b>1:40PM</b> , from the causes and on the date stated above.  <b>H. H. Baylus</b>						ADDRESS (Street, city or town, state) <b>Balto. 23, Md.</b>		DATE SIGNED <b>16 Dec 57</b>	
SIGNATURE <b>H. H. Baylus</b>									
PHYSICIAN'S NAME (Type) <b>H. H. BAYLUS</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/19/57</b>		22c. NAME OF CEMETERY OR CREMATORIY <b>London Park</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, INC. 715 Light St. -30</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 30 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John F. Denny</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician and can only be filed in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and can only be filed in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

СИМЕНС В. С.

1951

СИМЕНС В. С.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the reg. prior to burial, cremation, or removal.

Reg. Dist. No. 1283.3

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12850 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Balto.</i>		2. USUAL RESIDENCE [Where deceased lived if institution, Residence before admission] a. STATE <i>Md.</i> b. COUNTY <i>Baltimore.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Environs of Balto.</i>		c. LENGTH OF STAY IN 1b <i>18 yrs.</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Dear Park Rd.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Environs of Balto.</i>				
3. NAME OF DECEASED (Type or print) <i>JOSEPH PETER NAWROT</i>		First <i>JOSEPH</i>	Middle <i>PETER</i>			
Last <i>NAWROT</i>		4. DATE OF DEATH <i>Dec 14, 1884</i>	Month <i>Dec</i> Day <i>14</i> Year <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 14, 1884</i>			
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (in years from birth) <i>73 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Civil Serv.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Civil Serv.</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>			
12. CITIZEN OF WHAT COUNTRY? <i>Pol. Scl.</i>		13. FATHER'S NAME <i>Simon Joseph Nawrot</i>				
14. MOTHER'S MAIDEN NAME <i>Josephine Stachaj</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>				
16. SOCIAL SECURITY NO. <i>1910</i>		17. INFORMANT <i>710-09-6425 Bridget Nawrot</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)</b> <i>420.1</i> DUE TO <i>Emergency Excision.</i> INTERVAL BETWEEN ONSET AND DEATH <i>18 min.</i> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)						
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> 19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Nope</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>From</i>				
20c. TIME OF INJURY Month, Day, Year Hour <i>o. m.</i> p. m. <i>None</i> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>None</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>None</i>	(County) <i>None</i>	(State) <i>None</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>S. D. Caplin</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>12-4-57</i>		
EXAMINER'S NAME (Type) <i>I. D. CATES</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-7-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Family</i>	22d. LOCATION (City, town, or county) <i>Holbrook, Baltimore, Md.</i> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Father A. Haight Sykesville, Md.</i>	ADDRESS <i>Address</i>	24a. REC'D BY REGISTRAR <i>DEC 6 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Mary Oliver</i>			

221000

221000

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5, Film G-224 1/6/58. c.c.c.

12840  
Reg. Dist. No.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>Paradise Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
						d. STREET ADDRESS <b>2547 W. Fairmount Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN G. NEUBAUER</b>		First <b>JOHN</b>		Middle <b>G.</b>		Last <b>NEUBAUER</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>29,</b> Year <b>19 57</b>	
5. SEX <b>Male</b> <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 2, 1885</b>		9. AGE (In years last birthday) <b>72 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>die maker</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>George Neubauer</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Hospital Records</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO  (c)				BRONCHO PNEUMONIA.		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  <b>NO</b>							
20c. TIME OF INJURY Month, Day, Year Hour a. m.      0      19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>DEC. 24, 1957</b> , to <b>DEC. 29, 1957</b> , that I last saw the deceased alive on <b>DEC. 24, 1957</b> , and that death occurred at <b>10: AM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <i>S. Lloyd Johnson</i>		M.D.		6348 FREDERICK ROAD.		DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>S. LLOYD JOHNSON, M.D.</b>				CATONSVILLE BALTIMORE 28 MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/1/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Schinner &amp; Sons</i>		ADDRESS <b>Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 2 '57</b>		24b. REGISTRAR'S SIGNATURE <i>Dee L. Smith</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the record prior to burial, cremation, or removal, and in any event within 72 hours after death.

031

1996

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12841

Reg. Dist. No.

## 12852 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		1d STREET ADDRESS <b>207 S. Woodwell Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Winifred</b>	Middle <b>Oberholtzer</b>	Last <b></b>	4. DATE OF DEATH <b>Dec. 29 1957</b>	Month <b></b>	Day <b></b>	Year <b>57</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>April 23, 1893</b>	9. AGE (In years last birthday) <b>64</b> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months <b></b>	Days <b></b>	Hours <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James L. THOMAS</b>		14. MOTHER'S MAIDEN NAME <b>Winifred ? NOT KNOWN</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pneumonia - Congestive Failure - cystic's Malnutrition</b>						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <b>Nov. 12 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 12 1957</b> to <b>12-29 1957</b> , that I last saw the deceased alive on <b>12-29 1957</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>12-29-57</b>	
ACTUAL SIGNATURE <b>C. Eugene Wisterman</b>				SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) <b>C. Eugene Wisterman</b>				CATONSVILLE 28, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>12/29/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>WASHBURN ST. CEM.</b>		22d. LOCATION (City, town, or county) <b>SCRANTON PA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Inglewood Home - Catonsville, Md. H. H. H.</b>		ADDRESS <b></b>		24a. REC'D BY REGISTRAR DATE <b>1958</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. Hendry</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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REGELVADO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 717 Rev. 1-7-50  
12853 CERTIFICATE OF DEATH

1284238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md</b>		b. COUNTY <b>Balto</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wash</b>		c. LENGTH OF STAY IN 1b <b>RURAL and give nearest town</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Washington</b>		d. STREET ADDRESS <b>6072 Falls Road</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6072 Falls Road</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Mary E. Pahl</b>		First	Middle	Last	4. DATE OF DEATH <b>December 27, 1957</b>	Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>June 21, 1884</b>	9. AGE (In years less birthday) <b>74 yrs.</b>	10. IF UNDER 1 YEAR Months <b>7</b>	11. IF UNDER 24 HRS Days <b>17</b>	12. IF UNDER 24 HRS Hours <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Peter Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Helena A. Kluth</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Arnold Hust, 6072 Falls Road</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				<b>Carcinoma of cervix</b>		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Md</b> (State) <b>Md</b>
21. I certify that I attended the deceased from <b>Dec. 1, 1957</b> to <b>Dec. 28, 1957</b> that I last saw the deceased alive on <b>Dec. 27, 1957</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>M.D. 846 W. 36TH ST., BALTIMORE, MD.</b>		DATE SIGNED <b>12/30/57</b>
ACTUAL SIGNATURE <b>Reuben Hoffman</b>								
PHYSICIAN'S NAME (Type) <b>REUBEN HOFFMAN</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/31/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn</b>		22d. LOCATION (City, town, or county) <b>Woodlawn, Md.</b>		(State) <b>Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Austin E. Donovan - 3818 Roland Ave</b>		ADDRESS <b>15M 9/55</b>		24a. REC'D BY REGISTRAR <b>DEC 31 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Brays</b>		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the Burial-transit Permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12854

## CERTIFICATE OF DEATH

12843

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>22 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>72 Ritters Lane</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Henry</b>	Middle <b>Adam</b>	Last <b>Pape</b>	4. DATE OF DEATH <b>December 5 1957</b>	Month	Day	Year
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 2, 1884</b>	9. AGE (In years last birthday) <b>73 yrs</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Pape</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Knell</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH					
42 L. 1 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Generalized arteriosclerosis							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 13, 1957</b> , to <b>Dec. 5, 1957</b> , that I last saw the deceased alive on <b>Dec. 5, 1957</b> , and that death occurred at <b>8:30 a.m.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <b>Stella Wachsler</b>		DATE SIGNED <b>12-5-57</b>					
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		M.D. SPRING GROVE STATE HOSPITAL					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-7-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Cathedral Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers Home - Rockville, Md.</b>		ADDRESS <b>1401 Rockville Rd., Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 13 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Aut. each</b>	

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DEPARTMENT

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12855 CERTIFICATE OF DEATH**

12844  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville		c. LENGTH OF STAY IN 1b 3yr9mth1ldys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. STREET ADDRESS 4663 Pimlico Rd.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ida		First Ida Middle T.	4. DATE OF DEATH Month 12 Day 25 Year 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. ?, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME Muttle Faigenbaum		12. CITIZEN OF WHAT COUNTRY? Poland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
(a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO generalized arteriosclerosis	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 20, 1957, to 12/25, 1957, that I last saw the deceased alive on 12/25, 1957, and that death occurred at 10:50 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) STELLA WACHSLER M.D. SPRING GROVE STATE HOSPITAL DATE SIGNED 12/25/57	
ACTUAL SIGNATURE STELLA WACHSLER M.D. SPRING GROVE STATE HOSPITAL		PHYSICIAN'S NAME (Type) STELLA WACHSLER Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-57	22c. NAME OF CEMETERY OR CREMATORIAL Rosedale
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc 2100 Citrus Place		ADDRESS	24a. REC'D BY REGISTRAR DATE DEC 27 '57
			24b. REGISTRAR'S SIGNATURE Audrey

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12845				
12856 CERTIFICATE OF DEATH										Reg. Dist. No.				
1. PLACE OF DEATH a. COUNTY <b>Baltimore Maryland</b>					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>					c. LENGTH OF STAY IN lb <b>1½ Years</b>					b. COUNTY				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>									
3. NAME OF DECEASED (Type or print) <b>Grace Wheeler</b>					d. STREET ADDRESS <b>2414 St. Paul Street</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 3, 1876</b>		9. AGE (In years at birth) <b>81 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				
13. FATHER'S NAME <b>Joseph C. Wheeler</b>					14. MOTHER'S MAIDEN NAME <b>Sophia B. Medinger</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		(If yes, give war or dates of service)			16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Miss Dorothy B. Schneider</b>		Address <b>2414 St. Paul St.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Cardiac Failure</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>				
44 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral Virus Pneumonia</b>										3 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). <b>Arteriosclerotic Cardiovascular Disease</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o.m. p.m.		Month, Day, Year <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from <b>Feb. 1, 1957</b> , to <b>Dec. 26, 1957</b> , that I last saw the deceased alive on <b>Dec. 25, 1957</b> , and that death occurred at <b>5:20 A.M.</b> from the causes and on the date stated above.										ADDRESS (Street, city or town, State) <b>401 Raverty Road</b>				
ACTUAL SIGNATURE <i>Jerry J. Blaser</i>										DATE SIGNED <b>Dec. 27, 1957</b>				
PHYSICIAN'S NAME (Type) <i>Jerry J. Blaser</i>										<b>Practicing 29 Med.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 28, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)						
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc.</b>					ADDRESS <b>1217 St. Paul Street</b>					24a. REC'D BY REGISTRAR <b>DEC 30 '57</b>		24b. REGISTRAR'S SIGNATURE <i>Alfredus</i>		

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1957

REGIME

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12846

## 12857 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE			
BALTIMORE-COUNTY MARYLAND		MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
RURAL Catonsville		Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS				
Ridgeway Manor Home	4711 Frederick Ave.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First	Middle	Last		
MARY	Elizabeth		Peddicord		
4. DATE OF DEATH	Month	Day	Year		
	Dec	24	1957		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR, IF UNDER 24 HRS.
FEMALE	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 17, 1906	51 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clerk		Dept. Store		Balto. Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John J. Murphy		MARY BAKER		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Mrs. Agnes M. Reitz Frederick Ave.	
Address 4711					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Generalized Carcinomatosis		1 year	
153X DUE TO		Adenocarcinoma, Ovary			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b)		DUE TO			
		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I attended the deceased from Dec. 24, 1957, to Dec. 24, 1957, that I last saw the deceased alive on Dec. 24, 1957, and that death occurred at 11:40 P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, State) 401 Randolph Road Dec. 27, 1957	
ACTUAL SIGNATURE <i>Jolly J. Blawiey</i>		M.D.		DATE SIGNED Dec. 29, 1957	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 28, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Bur. Balto. Md.	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Truman Schub</i>		ADDRESS 3512 Frederick Ave. (29)		24a. REC'D BY REGISTRAR DATE 30-57	
				24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 A Lorraine

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OBITUARY

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PA3. Page 5 may be retained for files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12847-44 Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL (give nearest town) <b>Sparrows Pt.</b>					c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltv.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Beth Stue Hosp. Inc.</b>					d. STREET ADDRESS <b>6 N. Bond St.</b>				
3. NAME OF DECEASED (Type or print) <b>MANFIELD</b>					First <b> </b>	Middle <b> </b>	Last <b>Perkins</b>	4. DATE OF DEATH <b>Dec. 5 1957</b>	Month Day Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>BL.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>33 yrs.</b>		9. AGE, in years (not birthday) <b>33 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Craze Hooker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltv. Shipyard</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME <b>ANNIE PERKINS</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <b>Mrs Mary Perkins 6 N. Bond St</b>				
17. INFORMANT <b> </b>					Address <b> </b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>910.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Compound Fracture of SKULL left Fronto-Parietal Area -</b>									
INTERVAL BETWEEN ONSET AND DEATH									
MEDICAL CERTIFICATION									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, or item 18.) <b>Fallen Ship Photo CRUSHED head between Plat + Car -</b>				
20c. TIME OF INJURY Month, Day, Year Hour p. m. <b>(4) 12/5/57</b>					20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>Baltv. Shipyard</b>					20f. (City or town) (County) (State) <b>Sparrows Pt Baltimore Md</b>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>M.B. Davis</b>					DATE SIGNED <b>12/5/57</b>				
EXAMINER'S NAME (Type) <b>M. B. Davis MD</b>					MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BUR. A. CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>12/11/57</b>				
22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Zion Cemetery</b>					22d. STATE <b>VA.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy Wilson</b>					ADDRESS <b>1080 Brantley Ave</b>				
24a. REC'D BY REGISTRAR <b> </b>					24b. REGISTRAR'S SIGNATURE <b>Dawson L. Parker</b>				
DATE 12/9/57					DATE 12/9/57				

3 11 00

11 2 00

11 2 00

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12848

**Reg. Dist. No.**

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		o. STATE <u>Md.</u> b. COUNTY <u>Baltimore.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
<u>Hospital in the Hill Stone.</u>		<u>Towesville</u>			
3. NAME OF DECEASED (Type or print)		First <u>Elizabeth J.</u> Middle <u>Foster</u>		d. STREET ADDRESS <u>1600 Foster St.</u>	
4. SEX <u>Female</u>		5. COLOR OR RACE <u>White</u>		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH <u>Nov 11, 1876</u>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		7. IF UNDER 1 YEAR <u>Month</u> <u>Dec.</u> <u>Day</u> <u>12.</u> <u>Year</u> <u>1957.</u>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired).		9. AGE (in years last birthday) <u>81</u> yrs		10. KIND OF BUSINESS OR INDUSTRY <u>Media Examiner Katzenberger &amp; Co.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired).		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>US.</u>	
13. FATHER'S NAME <u>William H. Foster</u>		14. MOTHER'S MAIDEN NAME <u>Emma Jacob</u>		Address <u>William H. Foster 525 Edgewood St</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>William H. Foster</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE) <u>Coronary Arteritis</u>				INTERVAL BETWEEN ONSET AND DEATH	
DUE TO <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u> (b) <u>Coronary Disease</u>					
DUE TO <u>Diabetes or Arteritis Chronic</u> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>4123 Frederick Ave</u>	
20f. (City or town) <u>Baltimore</u>		(County) <u>Md.</u>		(State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Thru 10</u> , 19 <u>50</u> , to <u>Dec 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 11</u> , 19 <u>57</u> , and that death occurred at <u>4123 Frederick Ave</u> , M, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <u>4123 Frederick Ave</u>					
DATE SIGNED <u>12/13/57</u>					
ACTUAL SIGNATURE <u>JAMES W. KATZENBERGER M.D.</u>					
PHYSICIAN'S NAME (Type) <u>James W. Katzenberger</u>					
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/16/57</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Loudon Park Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Baltimore</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Brownlow</u>		ADDRESS <u>301 Halling St</u>		24a. REC'D BY REGISTRAR <u>REC'D 16 DEC 16 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Allineau</u>					

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
and retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with a registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. V. L. S.

W. G. E. V. P.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12849

## 12728 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. LENGTH OF STAY IN 1b c. STREET ADDRESS <b>51 Arbutus</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4215 Kensington Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>William H. Powell</b>		First	Middle			
		Last	4. DATE OF DEATH <b>Dec. 30, 1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
		8. DATE OF BIRTH <b>July 21, 1881</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Compositor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Sun Papers</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			
13. FATHER'S NAME <b>Josiah Powell</b>		14. MOTHER'S MAIDEN NAME <b>Cynthia Gossnell</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO <b>213-02-2729</b>	17. INFORMANT <b>Mary E. Powell 4215 Kensington Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <b>Seventeen days</b>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		DUE TO <b>Coronary occlusion</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension, arteriosclerotic C.I. disease</b>		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>4201 Wilkins Avenue</b>	20f. (City or town) <b>Baltimore</b>	(County) <b>Maryland</b>	(State) <b>M.D.</b>
21. I certify that I attended the deceased from <b>Dec. 29, 1957</b> to <b>Dec. 30, 1957</b> , that I last saw the deceased alive on <b>Dec. 29, 1957</b> , and that death occurred at <b>4201 Wilkins Avenue</b> , Baltimore, Md., from the causes and on the date stated above.						
ADDRESS (Street, city or town, state) <b>4201 Wilkins Avenue</b>						
DATE SIGNED <b>1/1/58</b>						
ACTUAL SIGNATURE <i>John F. Malahan M.D.</i>		PHYSICIAN'S NAME (Type) <b>John F. Malahan M.D.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Lunch</b>		22b. DATE THEREOF <b>1-3-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkins Avenue</b>	24a. REC'D BY REGISTRAR <b>1/3/58</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Murphy</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tranit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.  
IAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
this page should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12860

## CERTIFICATE OF DEATH

12850

Reg. Dist. No. 45

1. PLACE OF DEATH  
a. COUNTY

Baltimore MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Essex-Howley's Quarters

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

Route 15, Box 722

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Essex -- Bowleys Quarters

d. STREET ADDRESS

Seneca Road Box 722 Route 15

e. IS RESIDENCE  
ON A FARM?YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First BARBARA

Middle JEAN

Last PYLE

4. DATE  
OF  
DEATH

Month December Day 24 Year 1957

## 5. SEX

Female

## 6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED 

## 8. DATE OF BIRTH

Aug. 4, 1942

9. AGE (In years  
last birthday)  
yrs.IF UNDER 1 YEAR  
Months Days Hours Min

15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

## 10b. KIND OF BUSINESS OR INDUSTRY

School

## 11. BIRTHPLACE (State or foreign country)

Listie, Penna.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

John R. Pyle

## 14. MOTHER'S MAIDEN NAME

Sarah E. Whitfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes or no or unknown)

No

## 16. SOCIAL SECURITY NO.

None

## 17. INFORMANT

John R. Pyle

## Address

Seneca Road Box 722 (20)

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

1961

## DUE TO

Carcinoma - torso

INTERVAL BETWEEN  
ONSET AND DEATHConditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

## (b)

## DUE TO

Sarcoma (Brain)

## (c)

## MEDICAL CERTIFICATION

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. 19  
p. m.20d. INJURY OCCURRED  
While Not while  
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

## (County)

## (State)

21. I certify that I attended the deceased from 12-24, 1957, to 12-24, 1957, that I last saw the deceased alive on 12-24-57, 1957, and that death occurred at 10:50 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

Marie A. Goldstein, M.D. (University Hospital)

PHYSICIAN'S  
NAME (Type)22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

Dec. 27, 1957

## 22c. NAME OF CEMETERY OR CREMATORIUM

Gardens of Faith Cem.

## 22d. LOCATION (City, town, or county)

## (State)

Baltimore County, Maryland

## 23. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

William Cook, Inc. 1217 St. Paul Street

## 24a. REC'D BY REGISTRAR

DATE

## 24b. REGISTRAR'S SIGNATURE

DEC 30 1957

BUNAU V. S.

1957

REGELVÉD

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12861 CERTIFICATE OF DEATH

12851

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 this page should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal; and on any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CH. Sjex</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>J. Jiles Hospital</u>				d. STREET ADDRESS <u>51 Jiles Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>William</u>		First <u>Godwin</u>	Middle <u></u>	Last <u>Quillin</u>	4. DATE OF DEATH <u>Dec. 17, 1957</u>	Month <u>Dec.</u>	Day <u>17</u>	Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 2, 1888</u>	9. AGE (In years lost birthday) <u>69 yrs.</u>	10. IF UNDER 1 YEAR <u>Months</u>	11. IF UNDER 24 HRS <u>Days</u>	12. IF UNDER 24 HRS <u>Hours</u>	13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Layer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>							
13. FATHER'S NAME <u>William Quillin</u>		14. MOTHER'S MAIDEN NAME <u>MARY GODWIN</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>418-03-6005</u>		17. INFORMANT <u>rs. Stella J. Quillin</u>		Address <u>51 Jiles Road</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		DUE TO <u>Rebel hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30-72 hrs.</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <u>metastatic carcinoma</u>				 <u>6 mos.</u>					
(c)		DUE TO <u>Primary site undetermined</u>									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>51 Jiles Road</u>		20f. (City or town) <u>Baltimore</u>		(County) <u>Baltimore</u>		(State) <u>Maryland</u>	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>51 Jiles Road</u>											
ACTUAL SIGNATURE <u>J. Platt, M.D.</u>		M.D.								DATE SIGNED <u>12/18/57</u>	
PHYSICIAN'S NAME (Type) <u>J. Platt, M.D.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12/20/57</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Unknown Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore County</u>		(State) <u>Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Jaygothier</u>		1407 ADDRESS <u>Sherman Ave.</u>		24a. REC'D BY REGISTRAR <u>DEC 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hanley</u>					

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12852

## 12862 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
Balt. Co. MARYLAND		Md. Balt.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 16 Catovalie life	
Catovalie		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
e. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
Falon Ridge Cm. Home		Catovalie	
3. NAME OF DECEASED (Type or print)		First	Middle
MARY NELLIE RAPPANIER			last
4. DATE OF DEATH		Month	Day Year
1957		7/2	8 1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	2/27/1875
9. AGE (In years lost birthday) yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Hours Min.
82		0	0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Homemaker		at home	Md.
12. CITIZEN OF WHAT COUNTRY?		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Herman Kriete		Amelia Bergner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
(If yes, give war or dates of service)			Millard Traband
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		12 hours	
Coronary Occlusion			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Arteriosclerotic cardiovascular disease	
DUE TO		10 years	
(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2 September, 1957, to 8 December, 1957, that I last saw the deceased alive on 8 December, 1957, and that death occurred at 10:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE: <i>Millard Traband</i>		ADDRESS (Street, city or town, state) M.D. 5101 Gwynn Oak Ave. Balt. 7, Md. DATE SIGNED 12/9/57	
PHYSICIAN'S NAME (Type) Millard T. Traband, Jr., M.D.		22g. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22h. DATE THEREOF 12/11/57		22i. NAME OF CEMETERY OR CREMATORIAL Forest Park Balt. Co. Md.	22j. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>McNabb &amp; Son</i>		24a. REC'D BY REGISTRAR DATE DEC 11 '57	24b. REGISTRAR'S SIGNATURE <i>D. L. Traband</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S.A.C.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12869 CERTIFICATE OF DEATH

1285378

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Towson</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eudowood - Towson 4, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>324 Hyacinth Rd. - Roger J. Fox</b>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>LOUISE</b>	Middle <b>MARGRET</b>	Last <b>RAYSINGER</b>
4. DATE OF DEATH	Month <b>12</b>	Day <b>21</b>	Year <b>1957</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3/31/09</b>
9. AGE (In years from birthday) <b>48 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Legal Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Wm Kresser</b>		14. MOTHER'S MAIDEN NAME <b>Rita Stein</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>213-05-6857</b>	
17. INFORMANT <b>Personal History</b>		Address <b>Hospital Records, Eudowood Sanatorium</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix - Inoperable</b> DUE TO <b>with metastases to adnexa &amp; abdomen</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yr</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-16</b> , 19 <b>57</b> to <b>12-21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12-20</b> , 19 <b>57</b> , and that death occurred at <b>2:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Eudowood Sanatorium</b> DATE SIGNED <b>Milton B. Kress</b> M.D.			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Milton B. Kress, M.D.</b> Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-24-57</b>	22b. DATE THEREOF <b>12-24-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Holy Redeemer</b>	22d. LOCATION (City, town or county) <b>Baltimore Md</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Kuck</b>		ADDRESS <b>305 Mayfield</b>	24a. REC'D BY REGISTRAR DATE <b>DEC 24 1957</b>
		24b. REGISTRAR'S SIGNATURE <b>Ma. Kress</b>	

BUREAU V. S.

3 - 1957

MEGEVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12864 CERTIFICATE OF DEATH

12854

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto.		MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) o. STATE Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nurs. Ho.-100 N.Rolling Rd		d. STREET ADDRESS 5006 Edmondson Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First CARL	Middle REINHARDT	Last	4. DATE OF DEATH Month Dec.	Day 8,	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 7, 1901	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed-Operator		10b. KIND OF BUSINESS OR INDUSTRY Bakery	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles W. Reinhardt		14. MOTHER'S MAIDEN NAME Charlotte Weber				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT	Address Mrs. Freda Reinhardt - 5006 Edmondson Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause last.		cerebral thrombosis - Congestive pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 days.		
b) DUE TO		(b) DUE TO				
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Nov 1</u> , 1957, to <u>Dec 8</u> , 1957, that I last saw the deceased alive on <u>Dec 8</u> , 1957, and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>1604 Garrison Blvd.</u>				DATE SIGNED <u>Howard H. Warner</u>
ACTUAL SIGNATURE <u>Howard H. Warner</u>		PHYSICIAN'S NAME (Type) <u>HOWARD H. WARNER</u>				
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/57	22c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park Cem.	22d. LOCATION (City, town, or county) Woodlawn, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Linker &amp; Sons - Balto, Md.</u>		ADDRESS	24a. REC'D BY REGISTRAR DATE 12/10/57	24b. REGISTRAR'S SIGNATURE <u>R. H. Heidrich</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



20 V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12865 CERTIFICATE OF DEATH

12855

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE	
Baltimore MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 14 Eastern Blvd.		X2 Chase	
3. NAME OF DECEASED (Type or print) John A. Reinhardt		4. DATE OF DEATH Month Day Year December 11, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH April 14, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Balfiff-Retired		10b. KIND OF BUSINESS OR INDUSTRY Balto. City	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John A. Reinhardt		14. MOTHER'S MAIDEN NAME Kate Haas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Christina League		Address Box 14 Chase, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 14, 1957, to Dec 11, 1957, that I last saw the deceased alive on Dec 11, 1957, and that death occurred at 600 E. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 422 Eastern Ave., Baltimore, Md.			
ACTUAL SIGNATURE James G. White		DATE SIGNED Dec. 11, 1957	
PHYSICIAN'S NAME (Type) James White			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kraemer Funeral Home		ADDRESS 7401 Belair Rd.	
		24a. REC'D BY REGISTRAR DATE DEC 15 1957	
		24b. REGISTRAR'S SIGNATURE Newton L. Farber	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and solemnly filed in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. M.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12866

## CERTIFICATE OF DEATH

128568  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. LENGTH OF STAY IN 1b <i>1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1749 Forrest Avenue</i>		e. STREET ADDRESS <i>1749 Forrest Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Della C. Revis</i>		4. DATE OF DEATH <i>December 27th 1957</i>	Month Day Year
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 22, 1879</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Asheville, N.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>Asheville, N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Wheeler</i>		14. MOTHER'S MAIDEN NAME <i>Mary Banks</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Mr. Oliver D. Revis, 1749 Forrest Ave/</i>	
17. INFORMANT <i>Mr. Oliver D. Revis, 1749 Forrest Ave/</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1 (b) due to 2 (c) <i>Houseotoxicosis</i> 3 (c) <i>generalized arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5-10 yrs</i> <i>5-10 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>—</i> 19 p.m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) <i>None</i> (County) <i>None</i> (State) <i>None</i>	
21. I certify that I attended the deceased from <i>July 15, 1949</i> to <i>Dec 27, 1957</i> , that I last saw the deceased alive on <i>Dec 27, 1957</i> , and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Donald W. Mintzer</i>		ADDRESS (Street, city or town, state) <i>M.D. 3009 EVERGREEN AVE BALTO 14 MD</i>	
PHYSICIAN'S NAME (Type) <i>Donald W. Mintzer</i>		DATE SIGNED <i>12/27/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/30/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cem.</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road.</i>		24a. REC'D BY REGISTRAR <i>DEC 30 1957</i>	
		24b. REC'D STRA'S SIGNATURE <i>Bell M. Brooks</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

EC 5 1057

REGIME

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12867

## CERTIFICATE OF DEATH

12857

Reg. Dist. No. 44

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH o COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE <b>Maryland</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>353 Rosebank Avenue</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>W.</b>	Last <b>RHODES</b>	4. DATE OF DEATH <b>December 20</b>	Month <b>19</b>	Day <b>57</b>	Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/26/89</b>	9. AGE (In years from birthdate) <b>68</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Refrigeration Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Co.</b>		11. BIRTHPLACE (State or Foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Willis Rhodes</b>				14. MOTHER'S MAIDEN NAME <b>Mazie Moorehead</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-12-1359</b>		17. INFORMANT <b>Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOMEGLY WITH HYPERSTROPHY OF LEFT AND RIGHT VENTRICLES.</b> INTERVAL BETWEEN ONSET AND DEATH Unknown. DUE TO VENTRICLES.  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC AND HYPERTENSIVE CARDIAC DUE TO VASCULAR AND RENAL DISEASES.</b> Unknown. (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>December 14, 1957</b> , to <b>December 20, 1957</b> , and that death occurred at <b>11:00PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. VAH Fort Howard, Maryland</b> DATE SIGNED <b>12/21/57</b>								
ACTUAL SIGNATURE <i>Chien Wei Lan</i>		PHYSICIAN'S NAME (Type) <b>Chien Wei LAN, M.D.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-24-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National.</b>		22d. LOCATION (City, town, or county) <b>5501 Frederick Ave., Balt., Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Blight Inc.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>12/27/57</b>		24b. REGISTRAR'S SIGNATURE <i>Harold L. Shirley</i>		

BUKEAU V. E.  
DEC 30 1957  
REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**12868 CERTIFICATE OF DEATH**

12858 44

**Reg. Dist. No**

1. PLACE OF DEATH o COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE		b. COUNTY		
Baltimore				Maryland		H.H.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Fort Howard		40 days		Marley Heights				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Veterans Administration Hospital		201 1st Street						
3. NAME OF DECEASED (Type or print)		First	Middle	loss	4. DATE OF DEATH	Month	Day	Year
JOSEPH		F.	RITTMAYER		December	3	1957	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
Male		white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	March 16, 1882	Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Policeman		City Police Dept.		Pajern, Germany		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
John Rittmeyer		Dora Chick						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		Address		
Yes		8/22/09-8/16/22 220-24-6739		Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARCINOMA OF THE STOMACH				6 months		
1/5/18 DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Arteriosclerotic heart disease								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from October 24, 1957, to December 3, 1957, <del>and that death occurred at 1:25 A.M. from the causes and on the date stated above.</del>				ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL PHYSICIAN'S NAME (Type)		M.D.		VAH Ft. Howard, Md		12/3/57		
IRVING FREEMAN, M.D.,								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/57		22c. NAME OF CEMETERY OR CREMATORIUM Holy Cross Cemetery		22d. LOCATION (City, town, or county) (State) Ritchie Hwy, Balto. Md		
23. FUNERAL DIRECTOR'S SIGNATURE Hopkinson & Kirker		ADDRESS 421 Chain Highway, Glen Burnie, Md.		24. REG'D BY REGISTRAR FEC 6 1957		24b. REGISTRAR'S SIGNATURE Lewison L Farber		

BUNNAY V. A.

DEC 6 1962

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12859  
20

12869

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 55yr6mth7dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 2306 Mt. Royal Avenue	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Esther	Middle Rogers	Last December 31 1957
4. SEX female	6. COLOR OR RACE white	7. MARRIAGE STATUS WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1874
9. AGE (In years less birthday) 83	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Russia	12. CITIZEN OF WHAT COUNTRY? Russia
13. FATHER'S NAME Morris Kenefsky		14. MOTHER'S MAIDEN NAME Catherine Lechinsky	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Rev. no. or unknown) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT		Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized and severe			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 24, 1957, to Dec. 31, 1957, that I last saw the deceased alive on Dec. 31, 1957, and that death occurred at 11:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler		ADDRESS (Street, city or town, state) M.D. SPRING GROVE STATE HOSPITAL 12-31-57 DATE SIGNED	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/58	
22c. NAME OF CEMETERY OR CREMATORIAL St. Peters Cem.		22d. LOCATION (City, town, or county) Balto., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.M. Lechner & Sons		ADDRESS (7) DATE 1/2/58	
24a. REC'D/BY REGISTRAR		24b. REGISTRAR'S SIGNATURE A. H. Redding	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AN 3 1970

BUREAU A. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the remains or prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12870												12860 Reg. Dist. No. 99		
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hereford</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hereford</b>		d. STREET ADDRESS <b>Monkton Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Monkton Road</b>														
3. NAME OF -DECEASED (Type or print)		First <b>FRANCES</b>	Middle <b>MARIE</b>	Last <b>RUHL</b>	4. DATE OF DEATH	Month <b>December</b>	Day <b>9</b>	Year <b>1957</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29, 1909</b>	9. AGE (In years last birthday) <b>48</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. Months	14. Days	15. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Joshua Talbott Kelley</b>				14. MOTHER'S MAIDEN NAME <b>Mae Colgate</b>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT		Address <b>Preston Ruhl, Monkton Rd., Hereford, Md.</b>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Acute extensive esophagitis and gastritis</b>														
771.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Ingestion of pine oil deodorant compound</b>														
DUE TO (b) <b>Ingestion of pine oil deodorant compound</b>														
DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Ingestion of pine oil deodorant compound</b>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>12/9</b> p. m. <b>1957</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>			(County) <b>Baltimore</b> (State) <b>Md.</b>					
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>														
<b>R.W. Enslin</b>												DATE SIGNED <b>12/9/57</b>		
ACTUAL SIGNATURE												M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
NAME (Type) <b>Jim Burns, Son</b>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 12, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>May's Chapel Cemetery</b>		22d. LOCATION (City, town, or county) <b>Timonium, Maryland</b>		(State)						
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jim Burns, Son</b>		ADDRESS <b>Towson, Maryland</b>		24a. REC'D BY REG. STRR. <b>DEC 12 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Ely Garsch</b>								
VS. A1SME(5) 5M 9/55														

RECEIVED  
BUREAU V.

DEC 10 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12871 CERTIFICATE OF DEATH

12861

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c LENGTH OF STAY IN 1b <b>1 Day</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d STREET ADDRESS <b>831 Wildwood Parkway</b>		
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print)	First <b>EMIL</b>	Middle ---	Last <b>SAAL</b>	4. DATE OF DEATH <b>December</b>	Month <b>Day</b>	Day <b>17</b>	Year <b>19 57</b>	
S SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1874</b>	9. AGE (In years (at birthday) yrs. <b>83</b> )	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Business</b>		11. BIRTHPLACE (State or foreign country) <b>Panora, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Doyasal Saal</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Thomas</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>SAW</b>		17. INFORMANT <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURE OF ANEURYSM OF THE ABDOMINAL AORTA</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Arteriosclerosis (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>December 16, 1957</b> , to <b>December 17, 1957</b> , and that death occurred at <b>5:45 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Chien Wei Lan</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b> DATE SIGNED <b>12/18/57</b>								

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>12-18-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Tarkio Cemetery</b>	22d. LOCATION (City, town, or county) <b>Tarkio, Missouri</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Bright, Inc.</i>	ADDRESS <b>Wm. Cook-Bright, Inc., 6009 Harford Rd., Baltimore</b>	24a. REC'D BY REGISTRAR <b>DATE 12/27/57</b>	24b. REGISTRAR'S SIGNATURE <i>Person L Farley</i>

BUREAU Y. S.

DEC 30 1957

U.S. GOVERNMENT PRINTING OFFICE: 1957 6-1400-1

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD MEDICAL EXAMINER'S CERTIFICATE OF DEATH												Reg. Dist. No. 12862 41
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Baltimore								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 92 Dundalk Avenue				d. STREET ADDRESS 92 Dundalk Avenue								
e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) EDITH L. SAFLEY		First	Middle	Last	4. DATE OF DEATH December 10 1957	Month	Day	Year				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 25, 1912		9. AGE (in years from birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during year of death, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Bar Room		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US						
13. FATHER'S NAME Edward Dough												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Chas. F. Safley Sr. 92 Dundalk Ave		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy DUE TO Conditions, if any, which gave rise to immediate cause (b) (o), stating the underlying cause last. DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE 												
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>												
DATE SIGNED 12/10/57												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-13-57		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest		22d. LOCATION (City, town, or county) Louisa, Virginia				(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave ADDRESS												
24a. REC'D BY REGISTRAR DATE 12-13-1957 24b. REGISTRAR'S SIGNATURE 												

BUREAU V. S.

DEC 1957

RECEIVED

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with a formal P.M.I. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE  
HEALTH DEPT.

VIS AITSME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										12863	
12872										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE Maryland b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River (20)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (13)						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 185 Squehanna Avenue					d. STREET ADDRESS 3042 Mayfield Avenue						
e. IS RE BORN ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First ROSE	Middle ANNA	Last SCHLAUCH	4. DATE OF DEATH	Month December	Day 30	Year 1957			
5. SEX		6. COLOR OR RACE Female White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1911	9. AGE (in years last birthday) 43 yrs	10. IF UNDER 1 YEAR Months Days Hours Mins	11. IF UNDER 24 HRS				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Louis Lisy					14. MOTHER'S MAIDEN NAME Marianna Sykora						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Sebastian C. Schlauch, husband, above			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					INTERVAL BETWEEN INFORMANT AND DEATH						
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) Drowning											
929.8 Conditions, if any, which gave rise to immediate cause (b)											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
Lobar pneumonia, left lower lobe											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Apparently fell in water while in confused state due to pneumonia						
20c. TIME OF INJURY Hour: 4 p.m. Min: 30 m.		Month, Day, Year 12/30 1957	20d. INJURY OCCURRED at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Water		20f. (City or town) Baltimore		(County) Md.	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>R.S. Fisher</i>					M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 12/31/57	
EXAMINER'S NAME (Type)		Russell S. Fisher, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/58		22c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer Cem.			22d. LOCATION (City, town, or county) Baltimore, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home 3331 Brehms Lane		ADDRESS 240. REC'D BY REGISTRAR DATE JAN 3 1958 24b. REGISTRAR'S SIGNATURE <i>Edith Turley</i>									

BUREAU V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12864

12873

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>BALTO</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN lb <b>7 mos. 15 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE ST. HOSP.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODLAWN</b>	
d. STREET ADDRESS <b>WINDSOR MILL RD.</b>		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF (Type or print)	First <b>WILLIAM</b>	Middle <b>SCHMIER</b>	Last <b>12</b>
4. DATE OF DEATH <b>7-10-1887</b>	Month <b>7</b>	Day <b>10</b>	Year <b>1957</b>
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-10-1887</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		10. IF UNDER 1 YEAR OR UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. Md.</b>	
13. FATHER'S NAME <b>HENRY SCHMIER</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>UNKNOWN</b>	
17. INFORMANT <b>MRS. FRED. C. TYSON</b>		Address <b>4710 HADDON AVE BALT.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Infarction of Myocardium</b> DUE TO <b>Arteriosclerotic Coronary Thrombosis</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>10/5/57</b>	
(County) <b>10/5/57</b>		(State) <b>10/5/57</b>	
21. I certify that I attended the deceased from <b>4/23/57</b> to <b>10/5/57</b> , that I last saw the deceased alive on <b>10/5/57</b> , 19, and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>Bruno Radauskas M.D. Spring Grove St. Hospital</b>			
DATE SIGNED <b>12/8/1957</b>			
ACTUAL SIGNATURE <b>Bruno Radauskas M.D.</b>		PHYSICIAN'S NAME (Type) <b>Bruno RADAKUSKAS</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-10-57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>BALTIMORE</b>		22d. LOCATION (City, town, or county) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.T. STANSBURY</b>		ADDRESS <b>6411 Windsor Mill</b>	
24a. REC'D BY REGISTRAR <b>DATE REC'D 11/15/57</b>		24b. REGISTRAR'S SIGNATURE <b>G.W. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please return to the funeral director.

the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12865  
31

Reg. Dist. No.

## 12874 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Augsburg Home - 6811 Campfield Rd.		d STREET ADDRESS 2117 Belair Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN HENRY SCHMITT		First Middle Last	4. DATE OF DEATH Dec. 13, 1957	Month Dec.	Day 13
5. SEX male	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1880	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR IF UNDER 74 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen'l. Agt. (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Ald Asso. for Lutherans		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Henry C. Schmitt		14. MOTHER'S MAIDEN NAME Amelia R. Weyrich		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT Mrs. Lillian Koletschke - 1636 Northgate Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>(1) - Cerebral Hemorrhage</i> <i>301X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  (b) <i>2/ Broncho - Pneumonia</i> DUE TO DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>24 hrs</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <i>4/11/57</i> <i>- Generalized Arterio - Sclerosis</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 1 - 1957</i> , to <i>Dec. 13, 1957</i> , that I last saw the deceased alive on <i>Dec. 12, 1957</i> , and that death occurred at <i>7:30 AM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Earl L. Chambers		M.D. 4108 Liberty Hts - Balto - Md - 12-13-57			
PHYSICIAN'S NAME (Type) Earl L. Chambers -		4108 Liberty Hts Ave - Ad 12-13-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/57		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cem.	
23. FUNERAL DIRECTOR'S SIGNATURE Elmer J. Jackson & Sons - Balto, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 12/16/57	
				24b. REGISTRAR'S SIGNATURE Dorothy Jewell	

TO HOSPITAL  ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## INSTRUCTIONS

**To Attending Physician or Hospital:** The law requires that the death certificate be executed within 24 hours after death.

**To Funeral Director:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

12866

Reg. Dist. No. ....

12875

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY 1				
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) CATONSVILLE	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	(If rural give location)				
HOSPITAL OR INSTITUTION OR STREET ADDRESS House in Pines 16 Rustling Ave	STREET ADDRESS 120 S. Calhoun St.						
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH			
CHARLES C. SCHREINER				DEC. 9, 1957			
5. SEX MALE	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH July 7, 1886	9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXTERMINATOR			10b. KIND OF BUSINESS OR INDUSTRY Pest Control	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CHARLES SCHREINER				14. MOTHER'S MAIDEN NAME CHARA E. SCHEAVER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) YES World War I				16. SOCIAL SECURITY NO. 312-20-7269			
17. INFORMANT & ADDRESS Marie Smith 2118 W BALTO. ST.							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)		Bronchitis pneumonia					
ANTECEDENT CAUSES(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Epidermoid carcinoma, left side of tongue							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) M.D.		(County)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		(State)	
22. I hereby certify that I attended the deceased from 12-3, 1957, to 12-9, 1957, that I last saw the deceased alive on 12-9, 1957, and that death occurred at 11:57 A.M. from the causes and on the date stated above. SIGNATURE Milner K. Hollingsworth DATE SIGNED M.D. 52097 schreiner Baltimore 28 Dec. 12/10/57							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 12-12-57		NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL		LOCATION (City, town, or county) BALTIMORE Md.	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE George L. Schwab		DATE DEC 12 '57		25. FUNERAL DIRECTOR'S SIGNATURE George L. Schwab 2101 Frederick Ave.		ADDRESS	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12876

## CERTIFICATE OF DEATH

12867

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN.** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6637 Frederick Ave.		d. STREET ADDRESS 6637 Frederick Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Helen		First	Middle	Last	4. DATE OF DEATH Dec.	Month	Day	Year
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1874	9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Fred. Von Lindenber		14. MOTHER'S MAIDEN NAME Not Known						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Mrs. Murray Harrison 6637 Fred. Ave.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Cerebral. Atrophy, sclerosis.				INTERVAL BETWEEN ONSET AND DEATH days?		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from <u>Sept. 1, 1957</u> , to <u>Dec. 19, 1957</u> , that I last saw the deceased alive on <u>Aug. 26, 1957</u> , and that death occurred at <u>30</u> M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>Daniel E. Bogorad</u> M.D.						ADDRESS (Street, city or town, state) <u>1905 W. Baltimore St. Balto. Md.</u>		DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-57		22c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park		22d. LOCATION (City, town, or county) Woodlawn XXX		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville		ADDRESS Md.		24a. REC'D BY REGISTRAR JAN 3 1958		24b. REGISTRAR'S SIGNATURE <u>J. W. Gedney</u>		

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12877 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12868  
Reg. Dist. No.

38

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trouml permit. File pages 1 and 2 with the record prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
BALTIMORE MARYLAND		a. STATE MD.	b. COUNTY BALTO.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
TOWSON		55 TOWNSIN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
234 E. SUSQUEHANNA AV		234 E. SUSQUEHANNA	
f. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First MARY	Middle R. SCHROEDER Last
4. DATE OF DEATH		Month DEC	Day 30 Year 1957
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH NOV 1, 1916
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 47 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
BUTTER		11. BIRTHPLACE (State or foreign country) NY	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME UNKNOWN CLEVE		14. MOTHER'S MAIDEN NAME LEWIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT KENNETH (Husband)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) PNEUMONIA, RIGHT LOWER		5 DAYS	
490X DUE TO			
Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause first. (c)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?	
HYPERTENSIVE CARDIOVASCULAR DISEASE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William A. Pillsbury		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 2, 1958	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons		ADDRESS Towson, Md.	
		24a. REC'D BY REGISTRAR JAN 2 1958	
		24b. REGISTRAR'S SIGNATURE Hubel Gray	

SURMEAU V. S.

JAN 2 5 7

WEGELIN L.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12869

12878

## CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. LENGTH OF STAY IN 1b Life	b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 354 Silver Spring Rd.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First John F. Schultz	Middle	Last
4. DATE OF DEATH		Month Dec.	Day 29,	Year 1957

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1896	9. AGE (In years last birthday) 61 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Balto. Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Wendell Schultz	14. MOTHER'S MAIDEN NAME Minnie Slater
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. N.W. 1	17. INFORMANT Mrs. Rose E. Schultz	Address Box 354 Silver Spring Rd
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	Congestive Heart Failure 8 mos. Coronary Sclerotic Heart Dis 10 yrs.	INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day 19	Year 1957	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Fork, Md.	(County) Fork	(State) Md.
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21. I certify that I attended the deceased from 10/19, 1948, to 12/29, 1957, that I last saw the deceased alive on 12/29, 1957, and that death occurred at 5:13 P.M., from the causes and on the date stated above.								
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ACTUAL SIGNATURE CLIFFORD F. HUDSON MD.	ADDRESS [Street, city or town, state] Fork, Md.	DATE SIGNED 1958
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 2, 1958	22c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's	22d. LOCATION (City, town, or county) Fullerton	(State) Balto. Co. Md.
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23. FUNERAL DIRECTOR'S SIGNATURE Stanley Funeral Home 7401 Belair Rd.	ADDRESS JAN 2 1958	24a. REC'D BY REGISTRAR JAN 2 1958	24b. REGISTRAR'S SIGNATURE Mrs. G. L. Kennedy
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**ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

IAN 2 1959

112-2000-1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12879

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film 221 12-30-57 et

12870

Reg. Dist. No.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in pencil. If "Pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for records.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the record prior to burial or removal.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN ID 11mth5dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 27,	
3. NAME OF DECEASED (Type or print) Susan Elizabeth		4. DATE OF DEATH Sherman Month December Day 10 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1887
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown WALTER TUCKER		14. MOTHER'S MAIDEN NAME Unknown MARGARET CROSBY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown NONE	
17. INFORMANT Unknown		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904-7 DUE TO (b) Acute Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Acute sclerotic arterio vascular disease Fracture left femur Accident	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) by another patient on 8-19-57 sustaining an intertrochanteric fracture of left femur	
20c. TIME OF INJURY Hour 1:30 p.m. Month, Day, Year 8-19 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) Catonsville 28, Maryland (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE George M. Kieffer		DATE SIGNED 12-11-57	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, BURIAL (Specify) BUCHANAN		22b. DATE THEREOF 12-14-1957	
22c. NAME OF CEMETERY OR CREMATORIAL Friendship Methodist Church		22d. LOCATION (City, town, or county) Friendship	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Md.		24a. REC'D BY REGISTRAR DECEMBER 16 1957	
		24b. REGISTRAR'S SIGNATURE George M. Kieffer	

BEAUVILLE

DEC

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12871

12880

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reservoir</i>	c. LENGTH OF STAY IN 1b <i>Years</i>	b. COUNTY <i>Baltimore</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Reservoir</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Deer Park Road</i>	e. STREET ADDRESS <i>Deer Park Road</i>	d. STREET ADDRESS <i>Deer Park Road</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>CATHERINE ANN SHIPLEY</i>	First	Middle	Last		
4. DATE OF DEATH <i>December 23</i>	Month	Day	Year <i>1951</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 24 1867</i>		
9. AGE (In years lost birthday) <i>90 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>-</i>	12. CITIZEN OF WHAT COUNTRY <i>Maryland USA</i>		
13. FATHER'S NAME <i>Sixey Hob</i>	14. MOTHER'S MAIDEN NAME <i>Margaret Ann Frederick</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no—or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs. Anna Murray, deceased's daughter</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Reservoir</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>December 17, 1951</i> to <i>December 23, 1951</i> , that I last saw the deceased alive on <i>December 23, 1951</i> , and that death occurred at <i>4:15 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Catherine Ann Shibley</i> PHYSICIAN'S NAME (Type) <i>M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec 26-1951</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Deer Park Cemetery</i>	22d. LOCATION (City, town, or county) <i>Reservoir</i>	(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Berryman &amp; Sons</i>	ADDRESS <i>Reservoir</i>	24a. REC'D BY REGISTRAR <i>Date 12-26-51</i>	24b. REGISTRAR'S SIGNATURE <i>Mary B. Elkins</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGIEAU V. S.

RECEIVED

DEC 6 1971

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12881 CERTIFICATE OF DEATH**

12872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>?</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>5501 Ashbourne Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines Convalescent Home</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James</b>	First	Middle	Last	4. DATE OF DEATH <b>December 21, 1957</b>	Month	Day	Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/6/1891</b>	9. AGE (In years lost birthday) <b>66 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James D. Sigler</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. I</b>		17. INFORMANT <b>Mary E. O'Leary - 1521 Arbutus Avenue</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b>		Caudie Severe w.s. deficiency		INTERVAL BETWEEN ONSET AND DEATH <b>Two</b>			
DUE TO <b>(c)</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral Malacia</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>12/21/1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Baltimore</b>		(City or town) <b>Baltimore</b>		(County) <b>Baltimore</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Dec 20, 1957</b> to <b>Dec 20, 1957</b> , that I last saw the deceased alive on <b>Dec 20, 1957</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.								DATE SIGNED <b>Dec 27/57</b>	
ACTUAL SIGNATURE <b>Charles J. Tommasello</b>		ADDRESS <b>910 W. Lombard St. Baltimore Md.</b>							
PHYSICIAN'S NAME (Type) <b>Charles J. Tommasello MD</b>		22e. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22f. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)			
22g. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22h. DATE THEREOF <b>12/24/1957</b>		22i. REG'D BY REGISTRAR <b>DEC 23/57</b>		24b. REGISTRAR'S SIGNATURE <b>George J. Weber Jr.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Weber Jr.</b>		ADDRESS <b>5713 First Ave. - 27</b>							

I  
HOSPITAL ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD V. S.

DEC 22 1961



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12882 CERTIFICATE OF DEATH

12873

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>	c. LENGTH OF STAY IN TB <b>7 days</b>	b. COUNTY <b>BALTIMORE</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS <b>2900 Hillcrest Av</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>FREDERICK B. SISSON</b>	First	Middle	Last			
4. DATE OF DEATH <b>11/22/1869</b>	Month	Day	Year			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/22/1869</b>			
9. AGE (In years last birthday) <b>88 yrs</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>LOUIS Sisson</b>	14. MOTHER'S MAIDEN NAME <b>Willie Webb</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	16. SOCIAL SECURITY NO <b>220-07-53484</b>	17. INFORMANT <b>Hospital Record.</b>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c) <b>Generalized arteriosclerosis</b> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH probably several years</span>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>many years</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Spring Grove State Hosp.</b>	20f. (City or town) <b>Baltimore, Maryland</b>	(County) <b>Baltimore Co.</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>Dec 19, 1957</b> , to <b>Dec 16, 1957</b> , that I last saw the deceased alive on <b>Dec 16, 1957</b> , and that death occurred at <b>7:40 PM</b> , from the causes and on the date stated above.						
ACTUAL SIGNATURE <b>Bruno Radauskas</b>	ADDRESS (Street, city or town, state) <b>Spring Grove State Hosp.</b>			DATE SIGNED <b>12/16/57</b>		
PHYSICIAN'S NAME (Type) <b>Bruno Radauskas</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/19/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Parkwood Cemetery</b>	22d. LOCATION (Cty, town, or county) <b>Baltimore, Maryland</b>	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5305 Harford Road #14</b>	ADDRESS <b>Leonard J. Ruck 5305 Harford Road #14</b>	24a. REC'D BY REGISTRAR DATE <b>DEC 20 '57</b>	24b. REGISTRAR'S SIGNATURE <b>Alv. French</b>			

REGGIE V. S  
200 11 22

11 22

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12874

12883

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH  
a. COUNTY

BALTIMORE

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

OWINGS MILLS

c. LENGTH OF STAY IN lb

5 mo 15 days

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

Rosewood State Training School

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

MAY 20, 1948

9. AGE (In years  
last birthday)  
yrs

10. IF UNDER 1 YEAR

Months

Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

now

10b. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Albert Hamman Smith

14. MOTHER'S MAIDEN NAME

Mary Jane Langford

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)  
If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO

—

17. INFORMANT

Parents -

Address

502 Zuckerman Ave  
Fort Benning, GeorgiaINTERVAL BETWEEN  
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

351X

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

(c)

Aspiration Pneumonia - bilat

Cerebral Palsy and Epilepsy

## MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. p. m. 1920d. INJURY OCCURRED  
While Not while  
of work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 8-13, 1957, to 12-28, 1957, that I last saw the deceased  
alive on Dec 28, 1957, and that death occurred at 12:31 PM, from the causes and on the date stated above

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATUREPHYSICIAN'S  
NAME (Type)

Olive Reid Harris M.D. Rosewood Training School

Olive Reid Harris Owings Mills, Maryland

22a. BURIAL, CREMATION  
REMOVAL (Specify)

22b. DATE THEREOF

12/31/57

22c. NAME OF CEMETERY OR CREMATORIUM

Arlington National

22d. LOCATION (City, town, or county)

(State)

Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE

Frank J. Lovell, Elkridge, Md

ADDRESS

24a. REC'D BY REGISTRAR

DATE

JAN 2 1958 Mary Elene

BUREAU

JAN 2 1971

KENYA

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12884 CERTIFICATE OF DEATH

Reg. Dist. No. 12875-38

1. PLACE OF DEATH a. COUNTY <i>Balto.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
				a. STATE <i>Md.</i>	b. COUNTY <i>Balto.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN TB <i>15 yrs. 10 mths 26 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Delight, Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Spring Grove State Hosp</i>				d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i></i>	Last <i>Spring</i>	4. DATE OF DEATH <i>Dec. 6 1957</i>	Month <i></i>	Day <i></i>	Year <i></i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-1-66</i>	9. AGE (In years last birthday) <i>91 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. IF UNDER 24 HRS Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Spring</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Goldsmith</i>		Address <i>Records: Spring Grove Hospital</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i></i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>D Congestive failure</i>							
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i></i>		(b) Arteriosclerotic Cardio-vascular disease with myocardial hypertrophy and degeneration.					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>emphysema and chronic bronchitis malnutrition</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21. I certify that I attended the deceased from <i>Oct. 12, 1957</i> to <i>Dec. 6, 1957</i> , that I last saw the deceased alive on <i>Dec. 6, 1957</i> , and that death occurred at <i>2:00 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i></i>					
ACTUAL SIGNATURE <i>C. Eugene Waterman</i>		DATE SIGNED <i>12-6-57</i>					
PHYSICIAN'S NAME (Type) <i>C. Eugene Waterman, M. D.</i>		SPRING GROVE STATE HOSPITAL 12-6-57					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 10, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Druid Ridge Cemetery Pikeville</i>		22d. LOCATION (City, town, or county) (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sam Berryman &amp; Sons Registration Md.</i>		ADDRESS <i></i>		24a. NEED BY REGISTRAR DATE <i>12-7-57</i>		24b. REGISTRAR'S SIGNATURE <i>H. B. Ebene</i>	
						DEC 10 57	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

May V. S.

DEC

1960-1961

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12885 CERTIFICATE OF DEATH

12876

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOS. ITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
3. NAME OF DECEASED (Type or print) Jane Elizabeth		d. STREET ADDRESS Berrymans Lane	
4. DATE OF DEATH Stocksdale		Month December	Day 18
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 23, 1891	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Stocksdale		14. MOTHER'S MAIDEN NAME Annie Yax	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-03-5614	
17. INFORMANT Records: SPRING GROVE STATE HOS. ITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH unKnown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) congestive heart failure - mitral valve disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) metabolic cardiovascular disease	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Reisterstown	
(County)		(State)	
21. I certify that I attended the deceased from Dec. 3, 1957, to 12-18, 1957, that I last saw the deceased alive on 12-18, 1957, and that death occurred at 6 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank Taylor or sonally		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOS. ITAL	
DATE SIGNED			
PHYSICIAN'S NAME (Type) J. V. MCCELLIS M.D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-57	
22c. NAME OF CEMETERY OR CREMATORIAL All Saints Cemetery		22d. LOCATION (City, town, or county) Reisterstown	
(State)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John Berryman & Sons Reisterstown Md		24a. REC'D BY REGISTRAR DATE 12-20-57	
		24b. REGISTRAR'S SIGNATURE Mary B. Elie	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC

KINGMAN

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12886 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12877

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Sp. Pt.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 V O I - 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sparrows Point Hospital		d. STREET ADDRESS 1213 Mulberry Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Arthur AARON Middle	Last STOKES	4. DATE OF DEATH Month 12 Day 12 Year 19 57
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-7-91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		9. AGE (In years from birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Stokes		14. MOTHER'S MAIDEN NAME Virginia A. Shelton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  420.1		16. SOCIAL SECURITY NO. 213-07-9796 17. ANT Address Bethlehem Steel Co. Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. NONE 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) NONE	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, shop, office bldg., etc.) NONE	
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> ACTUAL SIGNATURE M. B. Davis, M.D. DATE SIGNED 12-13-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12-18-57	
22c. NAME OF CEMETERY OR CREMATORIUM Balto National		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel W. Sullivan Jr - Balto. Md.		24a. REGD BY REGISTRAR DEC 16 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE L. Farber	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the record prior to burial, cremation, or removal.

VS. ATME(5)  
SM 9/55

PUREAU V. S.

DEC 16 1964

U.S. MAIL  
V. S. BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12887

## CERTIFICATE OF DEATH

12878

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>	c. LENGTH OF STAY IN 1b <i>1 1/2 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>	d. COUNTY <i>Baltimore</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>College Manor</i>		d. STREET ADDRESS <i>Seminary ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>KATHARINE</i>	First <i>KATHARINE</i>	Middle <i>GUNTHER</i>	Last <i>STRINGER</i>
4. DATE OF DEATH <i>Dec. 11, 1957</i>	Month <i>Dec.</i>	Day <i>11</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 5-1886</i>
9. AGE (In years from birth) <i>71</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>George Gunther</i>	14. MOTHER'S MAIDEN NAME <i>Catherine Schleininger</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>710-</i>	17. INFORMANT <i>Mrs Howard C. Marchant.</i>	Address <i>222 Oakdale Rd., Baltimore 10, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma, Site undetermined, probably lung.</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>—</i>			
DUE TO (c) <i>—</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>—</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>arterio - Sclerotic Heart Disease; cerebral thrombosis</i>		
20c. TIME OF INJURY Hour p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May</i> , 19 <i>57</i> , to <i>Dec. 11</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Dec. 9</i> , 19 <i>57</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Conrad W. Kieley Jr.</i>	M.D.	ADDRESS (Street, city or town, state) <i>6 E. Eager St., Baltimore</i>	DATE SIGNED <i>Dec. 12, 1957</i>
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec 13, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Redeemer Cemetery</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins &amp; Sons Co.</i>	ADDRESS <i>4905 York Rd.</i>	24a. REG'D BY REGISTRAR DATE DEC 13 '57	24b. REGISTRAR'S SIGNATURE <i>Re. L. Smith</i>

W. V. S.

EC 70 10

REGGIEVILLE

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter "PENDING" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												12879					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												Reg. Dist. No.					
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived)			3. LENGTH OF STAY IN 1b			4. DATE OF DEATH			5. RESIDENCE ON A FARM?					
a. COUNTY			a. STATE			c. LENGTH OF STAY IN 1b			b. COUNTY			e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Baltimore			Maryland						Baltimore								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS			d. STREET ADDRESS								
Catonsville			Catonsville														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)																	
3. NAME OF DECEASED (Type or print)			First		Middle		Last		Month		Day		Year				
Frank			B.		Sullivan				December		7		19 57				
5. SEX			6. COLOR OR RACE		7. MARRIED		NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years, last birthday)		10. IF UNDER 14 YEARS				
Male			White		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		July 15, 1880		77 yrs		Months Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?								
Laborer - Retired			Baltimore City			Carroll Co. Maryland			U.S.A.								
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			Address											
George W. Sullivan			Elizabeth Bankard														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT											
No						None George S. Sullivan			2411 Rockwell Avenue								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Coronary thrombosis			INTERVAL BETWEEN ONSET AND DEATH								
			,0 X DUE TO														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			Elizabeth Mellitus											
			DUE TO														
			(c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
Right leg amputated several years ago, gangrene																	
20c. TIME OF INJURY Month, Day Year			20d. INJURY OCCURRED			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town)			(County)		(State)			
Hour a. m. p. m.			White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>														
19																	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												DATE SIGNED					
ACTUAL SIGNATURE			GEO. S. M. KIEFFER M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)															Kee 757		
22a. BURIAL, CREMATION REMOVAL (Specify)			22b. DATE THEREOF			22c. NAME OF CEMETERY OR CREMATORIAL			22d. LOCATION (City, town, or county)			(State)					
Burial			Dec. 10, 1957			Druid Ridge Cemetery			Baltimore Co. Maryland								
23. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS						24a. REC'D. BY REGISTRAR			24b. REGISTRAR'S SIGNATURE					
William Cook, Inc.			1217 St. Paul Street						DEC 11 '57			Bobbed					
VS A1MA																	
SM 2/57																	

S. V. A. U.

1972

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12880  
471

## 12729 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Highlands #27</i>		c LENGTH OF STAY IN lb <i>2 1/2 yrs</i>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Highlands #27</i>		d STREET ADDRESS <i>2919 Georgia Ave.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2919 Georgia Ave.</i>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Sophia</i>		First	Middle	Last	4. DATE OF DEATH <i>Temme</i>	Month	Day	Year			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 6, 1875</i>	9. AGE (in years last birthday) <i>82 yrs</i>	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>Germany</i>					
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Temme</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO <i>220-30-6462</i>					
17. INFORMANT <i>Mrs. Matilda Temme</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral Vascular Accident</i> <i>Generalized arteriosclerosis</i> <i>C.V.D.</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.			20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Glen Burnie</i>	(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Jan 2, 1957</i> to <i>Dec 1, 1957</i> that I last saw the deceased alive on <i>Dec 6, 1957</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Paul Schmied</i>		ADDRESS (Street, city or town, state) <i>2301 Annapolis Rd.</i>		DATE SIGNED <i>12/1957</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Inurn</i>		22b. DATE THEREOF <i>Dec. 19, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>London Park</i>		22d. LOCATION (City, town, or county) <i>Glen Burnie</i>		(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. D. Singleton</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>12/1957</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. George M. Kuffner</i>					

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

REC'D - 10 1557

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12881	Reg. Dist. No. 41	
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND					2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE MD.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEMERE					c. LENGTH OF STAY IN 1b 9 WKS							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2528 HADDANAHY RD.					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE							
3. NAME OF DECEASED (Type or print) Mildred K. Thompson					d. STREET ADDRESS 18 S. CATHERINE ST.							
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 15 1891		9. AGE (in years last birthday) 66 yrs		4. DATE OF DEATH DEC. 31, 1957		
10a. USUAL OCCUPATION (Give kind of work done during period of working life, even if retired) AW.			10b. KIND OF BUSINESS OR INDUSTRY OH.			11. BIRTHPLACE (State or foreign country) MD.			12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME UNKNOWN					14. MOTHER'S MAIDEN NAME WILHELMIA							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					17. INFORMANT JOHN H. THOMPSON, 18 S. CATHERINE ST, Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 45X DUE TO Pneumonitis										4 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO Multiple sclerosis (far advanced) (c)										2 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2. Fractured right hip.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from November 1, 1957, to Dec. 31, 1957, that I last saw the deceased alive on Dec. 31, 1957, and that death occurred at 9 PM, from the causes and on the date stated above. ACTUAL SIGNATURE Mildred Owens M.D. 914 D Street ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED 12/31/57												
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL JAN. 4/15/58					22b. DATE THEREOF JAN. 4/15/58					22c. NAME OF CEMETERY OR CREMATORIUM LONDON PARK		
23. FUNERAL DIRECTOR'S SIGNATURE WITZKE FUNERAL DIR. 4101 EDMONDSON					ADDRESS AVE.					24a. REC'D BY REGISTRAR DATE N 3 1958		
										24b. REGISTRAR'S SIGNATURE M. Kelly		

RECEIVED  
BUREAU V. S.

JAN 3

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be given to the funeral director. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12882

12890 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove Hospital</b>	d. STREET ADDRESS <b>116 E. Clement St.</b>	e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ANTHONY</b>	First <b>B.</b>	Middle <b>THUMAN</b>	4. DATE OF DEATH Month <b>December</b> Doy <b>15</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>4/18/02</b>	9. AGE (In years from birthday) <b>55</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret'd) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Poland Katz</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>	12. CITIZEN OF WHAT COUNTRY? IF UNDER 1 YEAR Months Doy Hours M'n	
13. FATHER'S NAME <b>Joseph</b>	14. MOTHER'S MAIDEN NAME <b>Mary Henneke</b>	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO	17. INFORMANT <b>Family - Sane</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatty Liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>William V. Lovitt</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <b>12/16/57</b>		
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>	22b. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>	22c. DATE THEREOF <b>12/18/57</b>	22d. NAME OF CEMETERY OR CREMATORIAL <b>Holy Cross</b>	22d. LOCATION (City, town, or county) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes - 130 E. Fort Avenue</b>	24a. REC'D BY REGISTRAR <b>REC'D 17-57</b>	24b. REGISTRAR'S SIGNATURE <b>Q. [Signature]</b>		

1961 A 1 C

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12891 CERTIFICATE OF DEATH

Reg. Dist. No. 128831

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - GRANITE</b>		c. LENGTH OF STAY IN 1b <b>70 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>OLD COURT RD. - GRANITE</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL - GRANITE</b>	
3. NAME OF DECEASED (Type or print) <b>ELLEN ELIZABETH TRAIL</b>		First <b>ELLEN</b>	Middle <b>ELIZABETH</b>
3. NAME OF DECEASED (Type or print) <b>ELLEN ELIZABETH TRAIL</b>	4. DATE OF DEATH <b>DEC 30 1955</b>	Last <b>TRAIL</b>	Month Day Year
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 13, 1867</b>
9. AGE (In years lost birthday) <b>90</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>	12. IF UNDER 24 HRS Min. <b>0</b>
10a. US LAB OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
10c. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN A. THRIFT</b>		14. MOTHER'S MAIDEN NAME <b>MARY HENRIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>DAUGHTER - BEULAH GOSNEL</b>		Address <b>OLD COURT RD. CRANITE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DEGENERATIVE HEART DISEASE</b>		11 YEARS	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 10, 1957</b> to <b>DEC 30, 1957</b> , that I last saw the deceased alive on <b>DEC 29, 1957</b> , and that death occurred at <b>922A M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edwin L. Pierpoint</b>		ADDRESS (Street, city or town, state) <b>8204 LIBERTY RD., BALTO, MD 21212</b>	
PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPOINT</b>		DATE SIGNED <b>1/30/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-2-58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Granite Pres. Cemetery</b>		22d. LOCATION (City, town, or county) <b>Granite, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers, 8728 Liberty Rd., Randallstown, Md.</b>		24c. REC'D BY REGISTRAR MS. REGISTRAR'S SIGNATURE <b>JAN 2 1958 Dr. John D. Martin</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURBAU V. S

JAN 2 1966

MCGRAW HILL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12892 CERTIFICATE OF DEATH

12884

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE <b>MD</b>		If institutions: Residence before admission <b>MONTGOMERY</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>		c. LENGTH OF STAY IN 1b <b>24 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRINGS</b>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>ELDRIDGE ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First <b>F</b> <b>LUTHER</b>	Middle <b>R</b> <b>RUSSELL</b>	Last <b>TYLER</b>	4. DATE OF DEATH	Month <b>12</b>	Day <b>19</b>	Year <b>1957</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/30/906</b>	9. AGE (in years last birthday) <b>51 yrs</b>	IF UNDER 1 YEAR <b>3 mos</b>	IF UNDER 24 HRS <b>9 days</b>	Hours <b>12</b>	Min <b>00</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (State or foreign country) <b>LEXINGTON VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>						
13. FATHER'S NAME <b>SAM TYLER</b>		14. MOTHER'S MAIDEN NAME <b>RACHEL SMITH</b>		Address								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-14-473</b>		17. INFORMANT Hospital Records, Mt. Wilson State Hospital								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		<b>OCARCINOMA OF LUNG, ② Pulmonary Tuberculosis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 days</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)										
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Maryland</b>		(State)		
21. I certify that I attended the deceased from <b>4/2/57</b> , 19 <b>57</b> , to <b>12/19/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12/14</b> , 19 <b>57</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Maryland</b>												
ACTUAL SIGNATURE <i>William Newcomer</i>		M.D. <b>William Newcomer, M. D., Superintendent</b>						DATE SIGNED				
PHYSICIAN'S NAME (Type) <b>William Newcomer</b>				22c. NAME OF CEMETERY OR CREMATORIAL <b>Montgomery Park</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>						
22e. BURIAL, CREMATION, REMOVAL (Specify) <b>12/24/57</b>		22f. DATE THEREOF <b>12/24/57</b>		22g. ADDRESS <b>Frank H. Jewell, Liberville, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 12/27/57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Elise</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank H. Jewell, Liberville, Md.</i>		ADDRESS										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
this page should be detached for use as the burial-transit permit. Then please refile carbon papers. Page 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LEAU V. 2

DEC 30 1957

NEGATIVE

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please exercise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
SM 2-57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12893 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12885  
31

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodlawn</i>		b. COUNTY <i>BALTO</i>	
c. LENGTH OF STAY IN 1b <i>WOODLAWN</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WOODLAWN</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>2650 W Park Drive</i>		d. STREET ADDRESS <i>2650 W. PARK DR.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Anna A. Wagner</i>		First <i>A.</i>	Middle <i>Wagner</i>
4. DATE OF DEATH Month <i>12</i>		Month <i>6</i>	Year <i>1957</i>
5. SEX <i>F.</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>8-19-02</i>		9. AGE (in years last birthday) <i>55 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H. W.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
10c. BIRTHPLACE (State or foreign country) <i>WESTMINSTER</i>		11. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>HARVEY RACINE</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>✓</i>	
17. INFORMANT <i>WM WAGNER 2650 W. PARK DR.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Blair Rock</i>		20f. (City or town) <i>Blair Rock</i> (County) <i>P.A.</i> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Wilmer K. Gallagher</i>		DATE SIGNED <i>12-6-57</i>	
EXAMINER'S NAME (Type) <i>Wilmer K. Gallagher</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/10/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Blair Rock</i>		22d. LOCATION (City, town, or county) <i>Blair Rock P.A.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. T. STANSBURY 6411 WINDSOR RD. BALTO. MD.</i>		24a. REC'D BY REGISTRAR <i>DEC 9 1957</i>	
ADDRESS <i>6411 WINDSOR RD. BALTO. MD.</i>		24b. REGISTRAR'S SIGNATURE <i>John H. Murphy</i>	

11.00

REGULAR

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12886

## 12894 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1019 Mt. Holly Street</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>First MYRLE</b>		Middle <b>BELL</b>		Last <b>WALTZ</b>		4. DATE OF DEATH <b>Month December Day 8 Year 1957</b>	Month Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1896</b>	9. AGE <b>65</b> last birthday <b>60 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Edgar Jenkins</b>		14. MOTHER'S MAIDEN NAME <b>Elsie B. Franklin</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Quentin Gunn, Same as above</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> INTERVAL BETWEEN ONSET AND DEATH								
443X DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)								
DUE TO								
(c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <b>12/9/57</b>
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-11-1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Taylorsville</b>		22d. LOCATION (City, town, or county) <b>Carroll Co., Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 19 57</b>		24b. REGISTRAR'S SIGNATURE 		

ROBERT V. S

EG 11 1967



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12895 CERTIFICATE OF DEATH

12887 ✓

**Reg. Dist. No**

1. PLACE OF DEATH a. COUNTY		Baltimore 19. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE b. COUNTY			
Sparrows Pt.		22 yrs		in			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Poplar Rd		# 1.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		
LILLIAN		L.	WATKINS		Month Day Year		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 46 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
Female	white	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SEPT 11. 1911			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housework		Own home		Alabama		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
T. Bay. Rochester		Julia Reid					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		Address	
No.				Marge Clark. as in # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Adeno carcinoma rectum				17 yrs	
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)		with generalized metastases.		6 months	
DUE TO		(c)		colostomy.		17 yrs	
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I attended the deceased from 7-1-1951 to 12/31/57 that I last saw the deceased alive on 12/30/57, and that death occurred at 10:30 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Louis N. Tellin, M.D. 6908 North Pt. Rd. 12/31/57							
PHYSICIAN'S NAME (Type) Louis N. Tellin, M.D. 6908 North Pt. Rd. 12/31/57							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
REMOVAL		7-2-58		FOREST HILL CEM. Birmingham, ALABAMA			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
John Cook-Bright		6009 Harford Road		DATE 11/7/57		Dawson L. Parker	

**HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**SUPERVISOR DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 1970

REGELVETO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12896

## CERTIFICATE OF DEATH

12888  
38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)	
				a. STATE Maryland	b. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RL RAL and give nearest town) Baltimore 12 X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 511 Dunkirk Rd.				d. STREET ADDRESS 511 Dunkirk Rd.	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Thekla	Middle Vollmer	Last Way	4 DATE OF DEATH 12-11
5. SEX female		6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-1-1896	9. AGE (in years lost b. birthday) 61 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY private schools		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Philip Vollmer		14. MOTHER'S MAIDEN NAME Matilda Osann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 220-30-0801		17. INFORMANT M.H. Way 511 Dunkirk Rd., Balto. 12, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 174X		DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 years.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 16 <sup>th</sup> , 1957, to Dec 11 <sup>th</sup> , 1957, that I last saw the deceased alive on Dec 9 <sup>th</sup> , 1957, and that death occurred at 7:30 A.M., from the causes and on the date stated above ACTUAL SIGNATURE <i>A.S. Chalfant</i> M.D. 6210 York Rd. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) Dr. A.S. CHALFANT BALTIMORE, 18. MD. DATE SIGNED <i>Dec 13 1957</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 12-13-57		22c. NAME OF CEMETERY OR CREMATORIUM Green Mount	
22d. LOCATION (City, town, or county) Balto. City, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Scott Brooks</i>		ADDRESS 622 York Rd., Towson, Md.		24a. REC'D BY REGISTRAR DATE DEC 13 1957	24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>

PUZANU V. S.

EC

LEGELVÉ

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
the page should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or interment, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												12889	
12897 CERTIFICATE OF DEATH												Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Pr. Geo. Co.</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>5yr 5mths 2dys</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale, Maryland</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>4803 Riverdale Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Rosa</b>	Middle <b>Mae</b>	lost Weeks	4. DATE OF DEATH <b>1875</b>	Month <b>December</b>	Day <b>1st</b>	Year <b>1957</b>					
S. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 12, 1895</b>	9. AGE (In years last birthday) <b>62 8 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William R. Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Harriett Kohlenberg</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO <b>unknown</b>		17. <b>1875</b>		Address							
Records: SPRING GROVE STATE HOSPITAL													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of right lung</b>													
163X DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____													
DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>Oct. 14, 1957</b> , to <b>Dec. 1, 1957</b> , that I last saw the deceased alive on <b>Dec. 1st, 1957</b> , and that death occurred at <b>5:15 p.m.</b> from the causes and on the date stated above.												ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>Stella Wachsler</i>		M.D.		SPRING GROVE STATE HOSPITAL		<b>12-2-57</b>		DATE SIGNED					
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		Catsville 28, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/4/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Glenwood Cemetery Wash.</b>		22d. LOCATION (City, town, or county) <b>D.C.</b>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Simmons Bros. 1661 Loca Rd. SE</i>		ADDRESS <i>HOPA</i>		24a. REC'D BY REGISTRAR <b>DEC 3 '57</b>		24b. REGISTRAR'S SIGNATURE <i>Altman</i>							
VS A15 (4) 1SM 9/55													

RECEIVED

DEC 4 1957

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12890

12898

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yrlymths28dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
3. NAME OF (Type or print) First Amelia Middle Caroline Last Wegner		4. DATE OF DEATH December 6 Month Day Year 1957	
5. SEX female white		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 15, 1869	
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY school	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles J. Wegner		14. MOTHER'S MAIDEN NAME Johanna Sleepack	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO with mitral insufficiency			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) malnutrition and dehydration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 21, 1957, to Dec. 6, 1957, that I last saw the deceased alive on Dec. 6, 1957, and that death occurred at 415 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE: <i>C. Eugene Watermann</i> MD: SPRING GROVE STATE HOSPITAL		ADDRESS (Street, city or town, state) DATE SIGNED 12-6-57	
PHYSICIAN'S NAME (Type) C. Eugene Watermann, M.D.		CATONSVILLE 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 9, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery		22d. LOCATION (City, town, or county) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>		24a. REC'D BY REGISTRAR DATE DEC 11 '57	
ADDRESS Ellsworth Armacost - 4600 Liberty Hghts. Ave.		24b. REGISTRAR'S SIGNATURE <i>Dee. 11 '57</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. To Funeral Director: After his certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UVA

1957

REVIVAL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12891

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Hall</i>		c. LENGTH OF STAY IN lb <i>104 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X- White Hall</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		d. STREET ADDRESS <i>- Beacon Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>SARAH Elizabeth White</i>		First	Middle	Last	4. DATE OF DEATH <i>Dec. 15</i>	Month	Day	Year <i>1957</i>	
S. SEX <i>F</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 20 1871</i>		9. AGE (In years last birthday) <i>86 yrs</i>	IF UNDER 1 YEAR Months <i>9</i>	IF UNDER 24 HRS Days <i>25</i>	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House keeper Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>White Hall</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Edward Harris</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Amos</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>220-30-1964</i>		17. INFORMANT <i>Anita Title, Relat white Hall Md</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>							INTERVAL BETWEEN ONSET AND DEATH		
332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fracture Neck of right femur</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) <i>—</i>							
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Parkton, Md.</i>	(County)	(State)			
21. I certify that I attended the deceased from <i>OCT. 11, 1957</i> , to <i>Dec. 15, 1957</i> , that I last saw the deceased alive on <i>Dec. 14, 1957</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Parkton, Md.</i> DATE SIGNED <i>12/15/57</i>									
ACTUAL SIGNATURE <i>A. M. France</i> M.D. PHYSICIAN'S NAME (Type) <i>A. M. FRANCE</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec 15 57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Pine Grove</i>	22d. LOCATION (City, town, or county) <i>White Hall Rd., Md.</i>		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mastor Edward James Franks</i>		ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR DATE 12-19-57		24b. REGISTRAR'S SIGNATURE <i>Marilla Lowood</i>				

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LIBRARY

DEC 22 1957

DEGMA

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

128988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>Brooklandville</u> years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Brooklandville</u>	
3. NAME OF DECEASED (Type or print) <u>John Mack</u>		d. STREET ADDRESS <u>1111 Carrollton Road</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1957</u>	
13. FATHER'S NAME <u>John G Whitridge</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Henderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Grandchildren</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized and coronary arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20e. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20g. (City or town) <u>Baltimore</u> (County) <u>Md</u> (State) <u>Md</u>	
21. I certify that I attended the deceased from <u>1946</u> to <u>Dec 15 1957</u> that I last saw the deceased alive on <u>Dec 14 1957</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>WALTER B. BUCK</u>		ADDRESS (Street, city or town, state) <u>185 Eager St Baltimore</u> DATE SIGNED <u>12/17/57</u>	
PHYSICIAN'S NAME (Type) <u>WALTER B. BUCK</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Dec 17/57</u> 22c. NAME OF CEMETERY OR CREMATORIUM <u>Greenlawn Cemetery</u> 22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn W. Morris</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 17 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Hubel Gray</u>	

BRUNAU V. S

DEC 17 1967

65-2791

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5, 6, &amp; 7, Film G223, 12/2/57

## CERTIFICATE OF DEATH

12893

Reg. Dist. No. 35~

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived) If institution, Residence before admission) b. STATE	
Baltimore, MARYLAND		Md. Baltimore.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Rural - Freedland		82 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Middletown Rd.		Rural - Freedland	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
Eli F. Wilhelm.		Dec. 7 1957	
5. SEX		6. COLOR OR RACE	
Male		White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		Divorced <input type="checkbox"/>	
Aug. 26 1875		9. AGE (In years at birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Carpenter.		Building.	
10c. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Freeland, Md.		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Peter F. Wilhelm.		Mary Ann Morrow.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		215-10-2999A Mrs. Susan Wilhelm, Freedland, Md.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion 3 days	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b)		Arterio sclerosis	
DUE TO			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
SIGNATURE A. M. France M.D.		PARKTON, Md. 12/19/57	
PHYSICIAN'S NAME (Type) A. M. FRANCE		PARKTON, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		12/10/57	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
Mt. Zion Cemetery		Free Land, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Jacob Hartenstein, New Freedom Pa.		24a. REC'D BY REGISTRAR	
		DATE 12/12/57	
		24b. REGISTRAR'S SIGNATURE	
		Chester F. Fender	

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Log 4  
 may be retained by the hospital or attending physician.  
 TO FILE: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DE LAU V. S

1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12894

44

## CERTIFICATE OF DEATH

12902

Reg. Dist. No.

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Baltimore Lodge Forest	MARYLAND LENGTH OF STAY (in this place) 25 Years	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lodge Forest
HOSPITAL OR INSTITUTION OR STREET ADDRESS	2110 Oak Road	STREET ADDRESS (If rural give location)	2110 Oak Road
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
(First) PREYTRICKA (Middle) WILLS (Last)		Dec. 6, 1957 19	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH August 5, 1874
9. AGE last birthday 85 yrs.	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Casper Gantz	14. MOTHER'S MAIDEN NAME Elizabeth Stein		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No.	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Mrs. Margaret Renner 2110 Oak Road.	
18. MEDICAL CERTIFICATION			
<b>I</b> DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <i>Cardiovascular Ht. Disease</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C) _____ <i>2 yrs.</i>			
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
<b>22. I hereby certify that I attended the deceased from... <u>June</u>, 19<u>57</u>, to... <u>Dec.</u>, 19<u>57</u>, that I last saw the deceased alive on... <u>Dec.</u>, 19<u>57</u>, and that death occurred at... <u>M.</u>, from the causes and on the date stated above.          SIGNATURE <i>J. T. Mann</i> ADDRESS (Street, city, town, state) <i>820 Dorsey Hall Rd.</i> DATE SIGNED <i>12-7-57</i>          M.D. <i>820 Dorsey Hall Rd.</i> DATE SIGNED <i>12-7-57</i> </b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Dec. 9, 1957	NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery	LOCATION (City, town, or county) Colgate, Md.
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <i>Howard L. Farley</i>		ADDRESS
DATE <i>12-13-57</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Ullrich Funeral Home 2112 Dundalk Av.</i>		

8. A. 111

ZSCT

13. A. 111

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12903

## CERTIFICATE OF DEATH

12895

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 255 Chatsworth Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. STREET ADDRESS 255 Chatsworth Ave.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Viola	Middle Wilson	4. DATE OF DEATH Dec. 24, 1957 Month Day Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
			12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Adam Keckner		14. MOTHER'S MAIDEN NAME Sarah Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Melvin W. Wilson, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoidosis (Pulmonary)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. p.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 19, 1957, to Dec. 24, 1957, that I last saw the deceased alive on December 24, 1957, and that death occurred at 5: A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 48 Main Street Reisterstown, Md.	
ACTUAL SIGNATURE <i>Martin E. Strobel</i>	DATE SIGNED 12/24/57		
PHYSICIAN'S NAME (Type) Martin E. Strobel M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Dec. 27/57		22c. NAME OF CEMETERY OR CREMATORIUM All Saints	
22d. LOCATION (City, town, or county) Reisterstown, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE 12-24-57	
		24b. REGISTRAR'S SIGNATURE <i>Mary B. Eline</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 it should be detached for use as the burial transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with  
 the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

REGEV V. S  
DEC 11 1972

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please exercise the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12904

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - White Hall</u>		b. COUNTY <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u> (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Graystone Rd.</u>		d. STREET ADDRESS <u>Graystone Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH <u>Dec. 8, 1957</u>	
f. SEX <u>M</u>		f. MONTH <u>Month</u>	
g. COLOR OR RACE <u>W</u>		g. DAY <u>Day</u>	
h. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		h. YEAR <u>Year</u>	
i. WIDOWED <input type="checkbox"/>		i. DATE OF BIRTH <u>2-26-1927</u>	
j. DIVORCED <input type="checkbox"/>		j. AGE (in years from b'day) <u>30 yrs</u>	
k. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>crane operator</u>		l. 10b. KIND OF BUSINESS OR INDUSTRY <u>steel co.</u>	
m. 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		n. 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
o. FATHER'S NAME <u>Wm. L. Wilson</u>		p. MOTHER'S MAIDEN NAME <u>Delie Hoover</u>	
q. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>yes</u>		r. 16. SOCIAL SECURITY NO. <u>219-22-3368</u>	
s. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o), stating the underlying cause lost. <u>Carbon monoxide</u>		t. 17. INFORMANT <u>Mrs. John Thomas, Graystone Rd., White Ha</u>	
t. DUE TO <u>Carbon monoxide</u>		u. INTERVAL BETWEEN ONSET AND DEATH	
v. Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. <u>(b)</u>			
w. DUE TO <u>(c)</u>			
x. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
y. 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		z. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
aa. 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		ab. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
ac. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		ad. 20f. (City or town) <u>White Hall, Md.</u>	
(County)		(State)	
ae. 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
af. ACTUAL SIGNATURE <u>A. M. France</u>		ag. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ah. EXAMINER'S NAME (Type) <u>A. M. France</u>		ai. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
aj. 22b. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		ak. 22c. DATE THEREOF <u>12-13-57</u>	
al. 22d. NAME OF CEMETERY OR CREMATORIUM <u>West Liberty Methodist</u>		am. 22d. LOCATION (City, town, or county) <u>White Hall, Md.</u>	
(State)		(State)	
an. 23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Scott Brooks</u>			
ao. ADDRESS <u>622 York Rd., Towson 4, Md.</u>		ap. 24a. REC'D. BY REGISTRAR <u>DEC 13 '57</u>	
ar. DATE		aq. 24b. REGISTRAR'S SIGNATURE <u>C. L. French</u>	

BUREAU V G

DEC

REGELVIL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12897

12905

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Montgomery Co</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>		c. LENGTH OF STAY IN lb <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		d. STREET ADDRESS <b>715-A GIST AVENUE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>LYMAN</b>	Middle <b>HENRY</b>	Last <b>WOLFF</b>	4. DATE OF DEATH <b>DECEMBER 19 1957</b>	Month	Day	Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 20, 1902</b>	9. AGE (In years lost, birthday) <b>54 yrs</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EDITOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GOV. PRINTING</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK A. WOLFF</b>		14. MOTHER'S MAIDEN NAME <b>LILLIAN JONES</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>184-05-2372</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 18 1957</b> to <b>Dec. 19 1957</b> , that I last saw the deceased alive on <b>Dec. 19 1957</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>William Newcomer, M.D.</b> PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D., Superintendent</b>		ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/23/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town or county) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gibney &amp; Humphrey,</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REG'D BY REGISTRAR DATE <b>D. Howell 12/23/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Howell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-permit. Then please remove carbon papers. Page 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957

1957

1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the remains or removal

12906		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH						12898	
Reg. Dist. No. 45									
Items 8 & 9 Film G-23 12/18/57 GTE									
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Gray Manor		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM?	
Gray Manor						Gray Manor		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2609 Gray Manor Terrace		d. STREET ADDRESS		2609 Gray Manor Terrace			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
MATILDA		HODGARD		December 11, 1957					
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	1877	9. AGE (In years last birthday)	80	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 16, 1874	86 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
It home						Maryland			U.S.A.
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
V.G.F. Filer					Mary P. Hass				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No.				Mrs. Celie Pauer, 2609 Gray Manor Terrace					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Arterio-Sclerotic Cardio-Vas. Disease</u> DUE TO (c) <u>Debility</u> INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of Item 18.							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>M.B. Davis</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) <i>M.B. Davis M.D.</i>		DATE SIGNED <i>12/12/57</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 14, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery		22d. LOCAT ON (City, town, or county) Colgate, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 410 Belair Road.		ADDRESS		24a. REC'D BY REGISTRAR Date 12/18/57		24b. REGISTRAR'S SIGNATURE <i>Mrs. Edith Hanley</i>			

BUNNELL

DEC 19

NEW YORK

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12907

## CERTIFICATE OF DEATH

Reg. Dist. No.

12899

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24 Chatsworth Ave.		d. STREET ADDRESS 24 Chatsworth Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hallie Elizabeth Woodward		4. DATE OF DEATH Dec. 17, 1957	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 12, 1891	
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) # North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME James Barker	
14. MOTHER'S MAIDEN NAME Frances Jane		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO 213-34-0405		17. INFORMANT John R. Gilbert, Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO PULMONARY EDEMA INTERVAL BETWEEN ONSET AND DEATH 48 HRS		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO ARTERIOSCLEROTIC C.V. DISEASE 9 YEARS (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) EMPHYSEMA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 27, 1948, to DEC. 17, 1957, that I last saw the deceased alive on DEC. 17, 1957, and that death occurred at 3 A.M., from the causes and on the date stated above.		ADDRESS (Street, city, or town, state) M.D. 4800 MARY ST. REISTERSTOWN, MD. DATE SIGNED 12/17/57	
ACTUAL SIGNATURE Martin E. Strobel		PHYSICIAN'S NAME (Type) MARTIN E. STROBEL	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 17, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Finksburg		22d. LOCATION (City, town, or county) (State) Finksburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE 12-15-57	
		24b. REGISTRAR'S SIGNATURE Mary B. Eline	

3 A. 0700

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100

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12908

## CERTIFICATE OF DEATH

12908-45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MD.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN lb <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>	
d. STREET ADDRESS <b>1404 WRIGHTS RD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John W. WRIGHT</b>	First <b>J</b>	Middle <b>W</b>	Last <b>R</b>
4. DATE OF DEATH <b>Dec. 11 1957</b>	Month <b>Dec.</b>	Day <b>11</b>	Year <b>1957</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-2-1900</b>
9. AGE (In years last birthday) yrs. <b>57</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sew - Food</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMPLOY</b>	11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>John W. WRIGHT</b>	14. MOTHER'S MAIDEN NAME <b>Deahl</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>216-07-6809</b>	17. INFORMANT <b>ANNIE WRIGHT (SAME)</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <b>1</b>	20f. (City or town) (County) (State) <b>422 Eastern Ave., Baltimore 21, Md.</b>
21. I certify that I attended the deceased from <b>July 1950</b> to <b>12/11/57</b> , that I last saw the deceased alive on <b>12/11/57</b> , 19 <b>57</b> , and that death occurred at <b>113A M.</b> from the causes and on the date stated above.			
ACTUAL <b>James Fluite</b>	ADDRESS (Street, city or town, state) <b>422 Eastern Ave., Baltimore 21, Md.</b>		
PHYSICIAN'S NAME (Type) <b>John G. Connelly - Essex Md.</b>	DATE SIGNED <b>12/11/57</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12-14-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>EAK-LAWN</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connelly - Essex Md.</b>	ADDRESS <b>1619</b>	24d. REC'D. BY REGISTRAR DATE <b>1619</b>	24e. REGISTRAR'S SIGNATURE <b>John G. Connelly</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 could be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUFFAUD V. A.

DEC 10 1957

WAGELIVE

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

Item 8 of 1-2-59 set 12901 ✓

**CERTIFICATE OF DEATH**

Reg. Dist. No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 16 <i>5 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4610 Lander Ave.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>71 Nanticoke, Md.</i>	
3. NAME OF DECEASED (Type or print) <i>Oscar R</i>		First <i>Oscar</i>	Middle <i>R</i>
4. SEX <i>Male</i>		5. COLOR OR RACE <i>White</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. DATE OF BIRTH / <i>18 Jan 1888</i>		8. DATE OF DEATH / <i>1 Dec 1957</i>	
9. AGE (In years last birthday) <i>89 yr.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	
10c. BIRTHPLACE (State or foreign country) <i>Unknown</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
12. FATHER'S NAME <i>Unknown</i>		13. MOTHER'S MAIDEN NAME <i>Unknown</i>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		15. SOCIAL SECURITY NO. <i>None</i>	
16. INFORMANT <i>Mr. Thompson - 4610 Lander</i>		17. ADDRESS <i>Baltimore, Md., 2724</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral accident</i>		INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arteriosclerosis</i>		years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>Nov 19</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none</i>		20f. (City or town) <i>none</i>	
(County) <i>none</i>		(State) <i>none</i>	
21. I certify that I attended the deceased from <i>January, 1956</i> , to <i>Dec 1957</i> , that I last saw the deceased alive on <i>20 Dec 1957</i> , and that death occurred at <i>8:15 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>William Goodman, M.D.</i>		ADDRESS (Street, city or town, state) <i>1334 Belvoir Avenue, Pt. 24 Dec, Baltimore 27, Md.</i>	
PHYSICIAN'S NAME (Type) <i>WILLIAM GOODMAN, M.D.</i>		DATE SIGNED <i>Dec 27, 1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>14 Dec 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ambrose Inc 1328 Belvoir Spring Rd</i>		24a. REC'D BY REGISTRAR DATE <i>Dec 27, 1957</i>	
ADDRESS <i>Ambrose Inc 1328 Belvoir Spring Rd</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. Leo M. Hoffman</i>	

BUREAU Y.

1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician and completely filled in by the funeral director.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12909 CERTIFICATE OF DEATH

12902

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1400 Edmondson Ave.,</b>		e. STREET ADDRESS <b>1400 Edmondson Ave.</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Robert</b>	Middle <b>J.</b>	Last <b>Wright</b>
4. DATE OF DEATH	Month <b>Dec.</b>	Day <b>26,</b>	Year <b>19 57.</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 24, 1908</b>
9. AGE (In years last birthday) <b>49</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
13. FATHER'S NAME <b>Walter C. Wright</b>	14. MOTHER'S MAIDEN NAME <b>Maybelle Anderson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT	Address <b>Hrs. Evelyn M. Wright 1400 Edmondson Ave.,</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>161X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
<b>Cerebral Metastasis</b> <b>3 wks</b> <b>Carcinoma of Larynx</b> <b>5 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/30</b> , 1956, to <b>3/26</b> , 1957, that I last saw the deceased alive on <b>12/26</b> , 1957, and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Victor F. King</i>	M.D.	ADDRESS (Street, city or town, state) <b>Catonsville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Victor F. King.</b>	DATE SIGNED <b>12/27/57</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-30-1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
24a. FUNERAL DIRECTOR'S SIGNATURE <i>I. Howard Strong</i>	ADDRESS <b>3207 W. North Ave.</b>	24b. REC'D. BY REGISTRAR DATE <b>DEC 30 '57</b>	24c. REGISTRAR'S SIGNATURE <i>Alfredus</i>

**RECEIVE**

REC 1057

**BUREAU V.**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12910 CERTIFICATE OF DEATH										12903 Reg. Dist. No. 44			
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>					b. COUNTY <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>					c. LENGTH OF STAY IN 1b <b>16 Days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>					d. STREET ADDRESS <b>2008 E. Lafayette Avenue</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>JOSEPH</b>	Middle <b>C</b>	Last <b>WIN</b>	4. DATE OF DEATH <b>December</b>	Month <b>7</b>	Day <b>19</b>	Year <b>57</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/9/94</b>			9. AGE (In years last birthday) <b>63</b> yr.	10. IF UNDER 1 YEAR Months <b>0</b>	Days <b>0</b>	11. IF UNDEP 24 HRS. Hours <b>0</b>	Min. <b>0</b>			
10a. US/AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Henry Wynn</b>					14. MOTHER'S MAIDEN NAME <b>Sarah Horton</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>220-03-4820</b>			17. INFORMANT <b>Clin.Rec.Vets.Admin.Hospital,Ft.Howard, Md.</b>			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE RECTUM WITH GENERALIZED METASTASIS</b> 154X (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO										INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <b>Baltimore</b>		(County) <b>Maryland</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from November 21, 1957, to December 7, 1957, and that death occurred at 12:40 AM, from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>M.D. VAH Fort Howard, Maryland</b>			
SIGNATURE <b>Chien Wei Lan</b>										DATE SIGNED <b>12/7/57</b>			
PHYSICIAN'S NAME (Type)		CHIEN WEI LAN, M. D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-11-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>				22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>		ADDRESS								24a. REC'D BY REGISTRAR <b>12/14/57 Dawson &amp; Farley</b>		24b. REGISTRAR'S SIGNATURE	
Charles R. Law Mortuary, 802-04 Madison Avenue, Balto., Md.													

LEHRZAU V. 2

190 13 1957

GEIWEDE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12911 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

129078

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE RURAL BALTIMORE						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1733 FOREST AV						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)		First JOHN	Middle HENRY	Last YAKEL	4. DATE OF DEATH Dec 20 1957	Month	Day	Year		
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 24, 1907	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk			10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Carroll Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Yakel				14. MOTHER'S MAIDEN NAME Johanna						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 216-07-7472		17. INFORMANT John Wm Byron 1733 Forrest Av (stepson)			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) Acut occlusion of coronary artery DUE TO stating the underlying cause lost. (c)										
INTERVAL BETWEEN ONSET AND DEATH immed										
few hours										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>John C. Hyle</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-20-57						
EXAMINER'S NAME (Type) John C Hyle MD										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/57		22c. NAME OF CEMETERY OR CREMATORIAL Moreland Mem Park		22d. LOCATION (City, town, or county) Baltimore, Maryland			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14									24a. REG'D BY REGISTRAR DEC 24 1957	24b. REG. STRG & SIGNATURE Dr. G. M. Bacon

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial; cremation, or removal.

WILDAU V. S

135575  
WILDAU

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12912 CERTIFICATE OF DEATH

Reg. Dist. No. 44

12905

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <i>50</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b>		c. LENGTH OF STAY IN 1b <b>41 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Baltimore (12)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>2538 Sycamore Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Frank</b>	First <b>P</b>	Middle <b>YARBOROUGH</b>	Last	4. DATE OF DEATH <b>December 22</b>	Month	Day	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Celored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1923</b>	9. AGE (In years lost birthday) <b>34 yrs.</b>	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Luther Yarborough</b>				14. MOTHER'S MAIDEN NAME <b>Malinda Marrian</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-12-6857</b>		17. INFORMANT <b>Clin. Rec. Vet. Admin. Hosp., Ft. Howard, Maryland.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>UN KNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
21. I certify that I attended the deceased from <b>Nov. 11 1957</b> , to <b>Dec. 22 1957</b> , and that death occurred at <b>2:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Chien Wei Lan</b> PHYSICIAN'S NAME (Type) <b>Chien Wei Lan, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-26-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Calvary</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>		ADDRESS		24a. RECEIVED BY REGISTRAR DATE <b>Dec. 3 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farber</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 will be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 2 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12913 CERTIFICATE OF DEATH

12906

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN lb <b>29 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>STRING GROVE STATE HOSP.</b>		e. STREET ADDRESS <b>— Odenton 02 X 02</b>	
3. NAME OF DECEASED (Type or print) <b>EUGENE W. YEAGER</b>		4. DATE OF DEATH <b>12/17 1957</b>	Month Day Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <b>Married</b>	8. DATE OF BIRTH <b>2/2/1879</b>
9. AGE (In years lost birthday) <b>78 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer WB &amp; A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>V.S.</b>	
13. FATHER'S NAME <b>JOHN T. YEAGER</b>		14. MOTHER'S MAIDEN NAME <b>ELLA CARROLL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Obliterative pericarditis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Infarctive myocardial fibrosis</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 121, 1928</b> to <b>Dec 17, 1957</b> , that I last saw the deceased alive on <b>Dec 17, 1957</b> , and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Stella Wachsler</b>		ADDRESS (Street, city or town, state) M.D. SPRING GROVE STATE HOSPITAL DATE SIGNED <b>12/17/57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 12/19/57	
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Druid Ridge Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Pikesville, Md.</b>		22e. LOCATION (City, town, or county) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tuckett Son Nath &amp; Rosen, Inc. 17</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 18 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. J. Tuckett</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HENRY - WILSONVILLE

CERTIFICATE OF DELIVERY

BUREAU V. S.

DEC 19 1957

RECEIVED